Mail Handlers Benefit Plan

http://www.mhbp.com

2005

A fee-for-service plan

and

a consumer-driven plan

with a preferred provider organization

Sponsored by: the National Postal Mail Handlers Union, a Division of LIUNA, AFL-CIO.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program and who are, or become, members or associate members of the National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO.

To become a member or associate member: If you are a non-postal employee/annuitant, you will automatically become an associate member of the National Postal Mail Handlers Union upon enrollment in the Mail Handlers Benefit Plan. There is no membership charge for members of the National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO.

Membership dues: $42 per year for an associate membership. New associate members will be billed by the Mail Handlers Union for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by the Mail Handlers Union for the annual membership.

Enrollment codes for this Plan:

451 High Option - Self Only
452 High Option - Self and Family
454 Standard Option - Self Only
455 Standard Option - Self and Family
481 Consumer Option – Self Only
482 Consumer Option - Self and Family

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

See the 2005 Guide for more information on accreditation

Special Notice: This is the first offering of the MHBP Consumer Option. You must make a positive election into Enrollment Code 481 or 482 to enroll.

Authorized for distribution by the:

United States
Office of Personnel Management
Center for
Retirement and Insurance Services
http://www.opm.gov/insure

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier lifestyle brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventive screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

Kay Coles James
Director

Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Mail Handlers Benefit Plan Notice of Privacy Practices

We protect the privacy of your protected health information as described in our current Mail Handlers Benefit Plan Notice of Privacy Practices. You can obtain a copy of our Notice by calling us at 1-800-410-7778 or by visiting our Web site: www.mhbp.com.

Table of Contents

Introduction

This brochure describes the benefits of the Mail Handlers Benefit Plan. The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO has entered into a contract (CS1146) with the United States Office of Personnel Management as authorized by the Federal Employees Health Benefit law. This Plan is underwritten by First Health Life and Health Insurance Company/Cambridge Life Insurance Company. The address for the administrative offices is:

Mail Handlers Benefit Plan
P.O. Box 24503
Tucson, AZ 85734

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Mail Handlers Benefit Plan
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the United States Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized Plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800-410-7778 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
    - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
   - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
   - Tell them about any drug allergies you have.
   - Ask about side effects and what to avoid while taking the medicine.
   - Read the label when you get your medicine, including all warnings.
   - Make sure your medicine is what the doctor ordered and know how to use it.
   - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of test or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     Exactly what will you be doing?
     About how long will it take?
     What will happen after surgery?
     How can I expect to feel during recovery?
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

Preferred Provider Organizations (PPO)

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. The Mail Handlers Benefit Plan is solely responsible for the selection of PPO providers in your area. Contact us at 1-800-410-7778 for the names of PPO providers or to request a PPO directory. You can also go to our Web site at www.mhbp.com. Continued participation of any specific provider cannot be guaranteed. When you phone for an appointment, please remember to verify that the health care professional or facility is still a PPO provider. If your doctor is not currently participating in the provider network, you can nominate him or her to join. Physician nomination forms are available on our web site, or call us and we'll have a form sent to you. You cannot change plans because of changes to the provider network.

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the regular non-PPO benefits apply. If you receive non-covered services from a PPO provider, the PPO discount will not apply and these services will be excluded from coverage. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as PPO or non-PPO. Services from providers outside the continental United States, Alaska and Hawaii will be considered at the PPO benefit levels.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.

Managed Network Providers

This Plan has a contract with United Behavioral Health to administer our mental health/substance abuse benefits for High Option and Standard Option. They have contracts with mental health professionals to provide these services. See Section 5(e).

MultiPlan Participating Providers

This Plan has a contract with MultiPlan. MultiPlan has entered into contracts with non-PPO hospitals/facilities and doctors that have agreed to discount their charges. The Plan will consider these healthcare providers as participating providers. Covered services from participating MultiPlan providers are considered at the MultiPlan negotiated rate subject to applicable deductibles, copayments and coinsurance. Since MultiPlan providers are not PPO providers, non-PPO benefit levels will apply.

Dental PPOs

This Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To find a preferred dentist in your area or to ask for information about our dental benefits, call 1-800-410-7778 or visit our Web site at www.mhbp.com.

How we pay providers

When you use a PPO provider or facility, our Plan allowance is the negotiated rate for the service. You are not responsible for charges above the negotiated amount.

Non-PPO facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. You may be responsible for amounts over the allowance.

If PPO providers are available where you receive care and you do not use them, your out-of-pocket expenses will increase. The Plan will base its allowance on a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area (see definition of Plan allowance, Section 12, for further details).

When we obtain discounts from MultiPlan participating hospitals/facilities and doctors, or through direct negotiations with other non-PPO providers, we pass along your share of the savings.

Your Rights

OPM requires that all FEHB Plans provide certain information to their members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you.

You can find out about case management, which includes medical practices guidelines, and how we determine if procedures are experimental or investigational.

If you want more information about us, call 1-800-410-7778, or write to: Mail Handlers Benefit Plan, P.O. Box 24503, Tucson, AZ 85734. You may also visit our Web site at www.mhbp.com.

Section 2. How we change for 2005

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes.

- In Section 3, under **Covered providers**, Alaska is designated as a medically underserved area in 2005. Maine, Utah and West Virginia are no longer designated as medically underserved areas in 2005.
- In Section 11, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 14, we revised the language regarding the Flexible Spending Account Program - FSAFEDS and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal High Option Self Only premium will increase by 55.6%. For High Option Self and Family your share will increase by 64.3%.
- Your share of the non-Postal Standard Option Self Only premium will increase by 40.4%. For Standard Option Self and Family your share will increase by 37.0%.
- The Standard Option calendar year deductible for PPO medical services and supplies and for treatment of mental health and substance abuse will be reduced to $600 per family. Previously, it was $750 per family.
- The calendar year prescription drug deductible will be reduced to $350 per person ($700 per family) under Standard Option. Previously, it was $400 per person ($800 per family).
- We changed the Standard Option benefit for treatment of medical emergencies and accidental injuries at PPO hospital emergency rooms and urgent care centers. These services will be subject to a $150 copayment per visit, which will be waived if the patient is admitted to the hospital from the ER. The benefit remains subject to the calendar year deductible. Previously, these services were subject to 10% member coinsurance.
- The copayment for PPO chiropractic services will be $5 per visit under the Standard Option. Previously, these services were subject to 10% member coinsurance.
- We increased benefits for PPO adult screenings under the Standard Option. Listed covered services will be reimbursed at 100% and not subject to the medical calendar year deductible. Previously, these services were subject to the medical calendar year deductible and 10% member coinsurance.
- Non-PPO Inpatient hospital charges will now be subject to the "blended rate" allowance (see Definitions, Section 12) under Standard Option. Please contact us to locate a PPO hospital. Your out-of-pocket expenses will increase if you do not use a PPO hospital when one is available to you.
- We added coverage for home intravenous (IV)/infusion therapy under the Standard and High Options. We will reimburse home IV services subject to a member coinsurance of 10% for PPO services and a member coinsurance of 30% for non-PPO services.
- DoD facilities within the United States will no longer be paid at the PPO benefit level.

New Consumer Option

- We added a high-deductible health plan (HDHP), the MHBP Consumer Option. (See Section 6). The Consumer Option covers most of the same services, supplies, drugs and devices as the Plan's High and Standard Options and is subject to the Plan's current definitions, limitations and exclusions.
  - The Consumer Option will contribute up to $1,000 per person or $2,000 per family to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) based on your enrollment date.
  - Preventive services are not subject to the annual deductible..
  - The Consumer Option will have a calendar year deductible of $2,250 per person, limited to $4,500 per family for PPO and non-PPO medical, mental health/substance abuse and pharmacy services.
  - The Plan will have an annual out-of-pocket maximum of $5,000 per person and $10,000 per family for PPO services and $7,000 per person and $15,000 per family for non-PPO services.

Other Changes

- The address for the administrative office has changed. See the Introduction.
- The address for filing medical and dental benefits has changed. See Section 9.
- We added Christian Science practitioners to the list of covered providers.
- We added certified registered nurse anesthetist (C.R.N.A.) to the list of covered providers.
- We clarified the definition of morbid obesity.
- We clarified the Plan's ambulance benefit to include transportation to or from another medical facility as part of an inpatient confinement.
- We clarified that medically necessary physical and occupational therapy is covered when received from a qualified professional therapist on an outpatient basis at a skilled nursing facility.
- We added coverage for pancreas transplants for approved diagnosis.
- We added multiple myeloma as an approved diagnosis for autologous tandem bone marrow transplants.
- We clarified the procedures for Subrogation. See Section 11.

Section 3. How you get benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-410-7778 or write to us at Mail Handlers Benefit Plan, P.O. Box 24503, Tuscon, AZ 85734. You may also request replacement cards through our Web site: www.mhbp.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use or who bills for the services. If you use PPO providers, you will pay less.

- **Covered providers**

We consider the following to be covered providers when they perform covered services within the scope of their license or certification:

- a licensed doctor of medicine (M.D.)
- a licensed doctor of osteopathy (D.O.)
- a licensed doctor of podiatry (D.P.M.)
- a licensed dentist
- a chiropractor (D.C.)
- a licensed registered physical therapist (R.P.T.)
- a licensed occupational therapist
- a licensed speech therapist
- a clinical psychologist
- a clinical social worker
- an optometrist
- an audiologist
- an acupuncturist
- a physician's assistant
- a nurse midwife
- a nurse practitioner/clinical specialist
- a nursing school-administered clinic
- a certified registered nurse anesthetist (C.R.N.A)
- a Christian Science practitioner listed in the Christian Science Journal
- a Christian Science nurse listed in the Christian Science Journal

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2005, the states are: Alabama, Alaska, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Freestanding ambulatory facility**. A facility which meets the following criteria: has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional. The Plan will apply its outpatient surgical facility benefits only to facilities that have been accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory HealthCare (AAAHC), or that have Medicare certification as an ASC facility.
- **Managed In-Network providers**. The Plan may approve coverage of providers who are not currently shown as Covered providers, to provide mental health/substance abuse treatment under the managed In-Network benefit for High Option and Standard Option. Coverage of these providers is limited to circumstances where the Plan has approved the treatment plan.
- **Hospital**. An institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other institution that is operated pursuant to law, under the supervision of a staff of doctors (M.D. or D.O.) and with 24-hour-a-day nursing services, and that is primarily engaged in providing:

  (a) general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

  (b) specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises under its control, or through a written agreement with a hospital or with a specialized provider of those facilities; or

  (c) a licensed birthing center.

  In no event shall the term "hospital" include any part of a hospital that provides long-term care or sub-acute care, rather than acute care, or a convalescent nursing home, or any institution or part thereof that:

  (a) is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged; or

  (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or

  (c) is operated as a school; or

  (d) is operated as a residential treatment facility regardless of its State licensure or accreditation status.
- **Christian Science nursing facility**. A facility which is approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.
- **Hospice**. A facility that:

  (a) provides primarily inpatient care to terminally ill patients;

  (b) is licensed/certified by the jurisdiction in which it operates;

  (c) is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor on call 24 hours a day;

  (d) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and

  (e) provides an ongoing quality assurance program.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

Transitional care:

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care:

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Services immediately at 1-800-410-7778.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for…

- **Your hospital stay**

Precertification is the process by which — prior to your inpatient hospital admission — we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

The precertification process also provides you with the opportunity to learn more about your benefit coverage and to help ensure that you are directed to facilities that participate in the PPO network, avoiding exposure to unnecessary out-of-pocket costs.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. In addition, if the stay is not medically necessary, we will not pay any benefits for the room and board charges. If the reason for the admission is for services or supplies we don't cover, non-covered cosmetic surgery, for example, we will not pay any benefits.

Any stay greater than 23 hours must be precertified.

How to precertify an admission

- You, your representative, your doctor, or your hospital must call the Plan at least two working days before admission. The toll-free number is 1-800-410-7778.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date and phone number;
  - Reason for hospitalization, proposed treatment or surgery;
  - Name of hospital or facility;
  - Name and phone number of admitting doctor; and
  - Number of planned days of confinement.

How to precertify an admission *(continued)*

- We will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. If the length of stay needs to be extended, follow the procedures below.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then you, your representative, your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then you, your representative, your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay is extended

If your hospital stay — including for maternity care — needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay room and board hospital benefits. We will pay 70% for covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay room and board inpatient hospital benefits. We will pay 70% for covered medical supplies and services that are otherwise payable on an outpatient basis.
- If you remain in the hospital beyond the number of days we approved and you do not get the additional days precertified, then:
  - we will pay inpatient benefits for the part of the admission that we determined was medically necessary, but
  - we will pay 70% of the covered medical services and supplies otherwise payable on an outpatient basis and will not pay room and board benefits for the part of the admission that was not medically necessary.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.
- Your stay is less than 23 hours.

• Other services

Some services require precertification or preauthorization.

- We require preauthorization of mental health/substance abuse services under the managed In-Network benefit for High Option and Standard Option. See Section 5(e).
- We require preauthorization of certain classes of drugs. See Sections 5(f) and 6(d).
- We require preauthorization of transplant services under the National Transplant Program. You or your physician must call 1-800-410-7778 to speak with a transplant case manager prior to your pre-transplant evaluation as a potential candidate for a transplant procedure. See Sections 5(b) and 6(c).
- We require precertification when Medicare Part B is the primary payer and an outpatient hospitalization exceeds 23-hours or results in hospital admission.

You should call us at 1-800-410-7778 before scheduling any outpatient procedures; we can help you locate a PPO facility.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

- **Copayments** A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

  Example: When you have High or Standard Option and see your PPO physician you pay a copayment of $20 per visit for adult members or $10 per visit for dependent children under age 22.

- **Deductible** A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. Copayments, coinsurance and any penalties do not count toward any deductible.

  High Option and Standard Option

  - The High Option calendar year deductible for covered medical services and supplies is $250 per person ($750 per family) for services received from PPO providers, and $300 per person ($900 per family) for services received from non-PPO providers. The Standard Option calendar year deductible for covered medical services and supplies is $300 per person ($600 per family) for services received from PPO providers, and $350 per person ($900 per family) for services received from non-PPO providers. Whether or not you use PPO providers, your deductible will not exceed the applicable non-PPO amounts. Under a family enrollment, the medical services and supplies deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for all family members reach the respective per family limit.
  - If you were continuously enrolled in the Plan for the entire prior year and did not meet the calendar year deductible for medical services and supplies for that year (based on claims received by the Plan by December 31 of that year), we will waive $125 per person (up to $375 per family) of that deductible for the current year if you are enrolled in the High Option, or $150 per person (up to $450 per family) of that deductible if you are enrolled in the Standard Option. Example 1: If family member A incurs only $249 of the $250 High Option deductible for 2004, we will waive $125 of the deductible for 2005. Example 2: If three family members each incur only $299 of the $300 Standard Option deductible for 2004, we will waive $150 of the deductible for 2005 for each of these family members. This waiver does not apply to any other deductible under this Plan. This deductible waiver will apply even if you change options of the Plan in the current year. If you change options in this Plan during Open Season, the waiver amount will be based on your new option. This waiver is available only for High Option and Standard Option.
  - The calendar year deductible for covered mental health/substance abuse services under High Option is $250 per person, limited to $750 per family, for services received from managed in-network providers and $300 per person, limited to $900 per family, for services received from non-network providers. The calendar year deductible for covered mental health/substance abuse services under Standard Option is $300 per person, limited to $600 per family, for services received from managed in-network providers and $350 per person, limited to $900 per family, for services received from non-network providers. Whether or not you use PPO providers**,** your deductible will not exceed the applicable non-PPO amounts. This deductible is in addition to the medical services deductible. Under a family enrollment, the mental health/substance abuse services deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible reach the respective per family limit.
  - The calendar year deductible for prescription drugs is $200 per person under High Option and $350 per person under Standard Option. Under a family enrollment, this deductible is met when the family has incurred $400 under High Option and $700 under Standard Option. The prescription drug deductible does not apply to generic drugs. The prescription drug deductible is waived for members who have Medicare Parts A and B as their primary coverage.

  Note: If you change plans or plan options during Open Season, you do not have to start a new deductible under your old plan or plan option between January 1 and the effective date of your new plan or plan option. And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option

  - If you change plans during the year, you must begin a new deductible under your new plan.

- **Deductible *(continued)***

In 2005, we are introducing a new Consumer Option. Under the Consumer Option, you will have a Health Savings Account (HSA) if you are eligible or a Health Reimbursement Arrangement (HRA). An HSA is an account which you own. An HRA is a credit account which is used to pay for qualified out-of-pocket expenses. Due to Federal income tax rules, different cost sharing requirements apply to these options as explained below. For more information on the Consumer Option see Section 6.

Consumer Option (HSA):

- The calendar year deductible for covered medical services and supplies, mental health/substance abuse services, and prescription drugs, is $2,250 for a Self Only enrollment and $4,500 for a Self and Family enrollment.

Consumer Option (HRA):

- The calendar year deductible for covered medical services and supplies, mental health/substance abuse services, and prescription drugs, is $2,250 for a Self Only enrollment and $4,500 for a Self and Family enrollment. This includes your HRA credit amount and your Member Responsibility.

- **Coinsurance**

High Option and Standard Option

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 30% of our allowance for non-PPO office visits.

Consumer Option (HSA or HRA)

Coinsurance is the percentage of our allowance that you must pay under Traditional Health Coverage. Coinsurance does not begin until you meet your deductible (HSA) or your Member Responsibility (HRA).

Example: You pay 40% of our allowance for non-PPO office visits.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a covered service but routinely waives your 30% coinsurance (High Option or Standard Option), the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

To help keep your coinsurance out-of-pocket costs to a minimum, we encourage you to call us at 1-800-410-7778 or visit our Web site at www.mhbp.com for assistance locating PPO providers whenever possible.

- **Member Responsibility**

Consumer Option (HRA Only):

Your Member Responsibility is your bridge between your Health Reimbursement Arrangement (HRA) and your Traditional Health Coverage. After you have exhausted your HRA credit, you must pay your Member Responsibility before your Traditional Health Coverage begins. Your Member Responsibility is $1,250 for a Self Only enrollment or $2,500 for a Self and Family enrollment.

- **Differences between our allowance and the bill**

High Option and Standard Option: Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 12.

Often, the provider's bill is more than a fee-for-service Plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible, coinsurance or copayment. Here is an example: You see a PPO physician for an office visit who charges $150, but our allowance is $100. You are only responsible for your copayment. That is, you pay just $20 of our $100 allowance for an adult office visit. Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance - **plus** any difference between our allowance and the charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, you can be billed for the $50 difference between our allowance and the physician's charge. For details on how we determine the Plan allowance, please see Section 12.

MultiPlan providers agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay under High Option if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: $100	We set it at: $100
We pay	$80	70% of our allowance: $70
You owe:		
Copayment	$20	30% of our allowance: $30
+ Difference up to charge	No: $0	Yes: $50
TOTAL YOU PAY	$20	$80

Consumer Option:

- **PPO providers** agree to accept our Plan allowance so if you use a PPO Provider, you never have to worry about paying the difference between the Plan's allowance and the billed amount for covered services.
- **Non-PPO Providers**: If you use a non-PPO provider, you will have to pay the difference between the Plan allowance and the billed amount.

After you have exhausted your HSA or HRA, you will be responsible for paying your remaining deductible and also copayments and coinsurance under the Traditional Health Coverage.

Note: We encourage you to use PPO providers because it will make the amounts in your HSA or HRA last longer.

Your catastrophic protection (out-of-pocket maximum for coinsurance)

High Option and Standard Option:

For those services with coinsurance (excluding mental health and substance abuse care), we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $4,500 for services of PPO providers/facilities under the High and Standard Options
- $9,000 for services of PPO and non-PPO providers/facilities, combined, under the High and Standard Options.

For mental health and substance abuse benefits, we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total:

- $4,500 for services of in-network providers/facilities under the High and Standard Options.

Note: Your out-of-pocket maximum does not apply to these benefits and you must continue to pay applicable copayments and coinsurance for these expenses:

- Skilled nursing care
- Prescription drugs
- Any out-of-network mental health and substance abuse care
- Hospice
- Dental services
- Rehabilitative and alternative therapies

Note: The following cannot be counted toward out-of-pocket expenses:

- Deductibles
- Copayments
- Expenses incurred under Prescription Drug Benefits
- Expenses in excess of the Plan allowance or maximum benefit limitations
- Any out-of-network expenses for mental health and substance abuse care
- Amounts you pay for non-compliance with this Plan's cost containment requirements
- Coinsurance for skilled nursing care
- Non-covered services and supplies
- Coinsurance for alternative and rehabilitative therapy

Your catastrophic protection (out-of-pocket maximum for coinsurance) *(continued)*

Consumer Option:

PPO benefit: Your catastrophic out-of-pocket maximum is $5,000 per person ($10,000 per family) when you use PPO providers/facilities and pharmacies. Only eligible expenses for network providers count toward this limit.

Out of pocket expenses for purposes of this benefit are:

- Your annual deductible and the in-network copayments that you pay under the Traditional Health Coverage.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of the Plan's allowance, or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 13-14)

Non-PPO benefit: Your catastrophic out-of-pocket maximum is $7,500 per person ($15,000 per family) when you use non-PPO providers/facilities. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Out-of-pocket expenses for the purposes of the benefit are:

- The copayments you pay for in-network inpatient and outpatient hospital charges, surgical, medical, maternity and emergency services under the Traditional Health Coverage
- Your annual deductible and the 40% you pay for out-of-network inpatient and outpatient hospital charges, surgical, medical, maternity and emergency services under the Traditional Health Coverage

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of the Plan's allowance, or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Expenses for out-of-network mental health or substance abuse care
- Amounts you pay for non-compliance with this Plan's cost containment requirements
- Coinsurance for skilled nursing care
- Coinsurance for alternative and rehabilitative therapy

• Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When you are age 65 or over and you do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital and non-physician based care is not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you…

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount — the "equivalent Medicare amount" — set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your coinsurance and any applicable deductibles or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

And, for your physician care, the law requires us to base our payment and your coinsurance on…

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us at 1-800-410-7778.

When you have the Original Medicare Plan (Part A, Part B, or both)

High Option and Standard Option

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

When Medicare is primary, all or part of your Plan deductibles, copayments and coinsurance will be waived as indicated below:

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance abuse benefits and nursing benefits.
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance abuse services.
- When Medicare Parts A and B are primary, the Plan will waive the calendar year deductible for prescription drugs purchased at a retail pharmacy and through the mail order prescription drug program for both High Option and Standard Option.

Note: The Plan will not waive the copayment and coinsurance for retail or mail order prescription drugs.

It's important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

Please see Section 11, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Consumer Option (HRA):

- If your physician accepts Medicare assignment, then you pay nothing if you have unused credit available under your HRA to pay the difference between the Medicare approved amount and Medicare's payment. After your HRA is exhausted and your Member Responsibility has been met, you pay either the difference between the Medicare approved amount and Medicare's payment or your copayment amount, whichever is less.

Note: The Plan will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payer.

Section 5. High Option and Standard Option Benefits – OVERVIEW

(*See page 9 for how our benefits changed this year and pages 126 and 128 for a benefits summary.)*

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 8; they apply to the benefits in the following subsections. To obtain claim forms, claim filing advice, or more information about our benefits, contact us at 1-800-410-7778 or at our Web site at www.mhbp.com.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family) for Standard Option PPO services and $350 per person ($900 per family) for Standard Option non-PPO services; and $250 per person ($750 per family) for High Option PPO services and $300 per person ($900 per family) for High Option non-PPO services. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles (including the deductible waiver) and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a provider participating in the **First Health®** Network. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Christian Science Practitioners	Same as above	Same as above
Same-day services performed and billed in conjunction with the office visit (except allergy shots, rabies shots or routine immunizations)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians during a hospital stay Note: Outpatient cancer treatment (chemotherapy, X-rays, or radiation therapy) and dialysis services are paid under Treatment therapies, page 30.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Routine physical checkups and related tests except those covered under preventive care* • *Thermography and related visits* • *Chelation therapy and related services provided in an outpatient setting* • *Orthoptic visits and related services* • *Telephone consultations*	*All charges*	*All charges*
Lab, X-ray, and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
First Health® Lab Program You can use this voluntary program for covered lab tests. You show your Mail Handlers Benefit Plan identification card and ask your doctor to send your lab order to Quest Diagnostics. As long as Quest Diagnostics does the testing and bills us directly, you will not have to file any claims. To find a location near you, call 1-800-377-7220, or visit our Web site at www.mhbp.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.
Not Covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests*	*All charges*	*All charges*

Preventive care, adult	You Pay — Standard Option	You Pay — High Option
Routine screenings, limited to: • Mammogram for women age 35 and older: – From age 35 to 39 — one during this five year period – From age 40 to 64 — one every calendar year – At age 65 and older — one every two consecutive calendar years • Pap smear — one per calendar year for women age 18 and older Note: The office visit is covered if pap test is received on the same day. • Prostate Specific Antigen (PSA) test— one per calendar year for men age 40 and older • Colorectal cancer screenings: – Fecal occult blood (stool) test — one per calendar year for members age 40 and older – Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older – Colonoscopy – one every 10 years for members age 50 and older • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Chlamydial infection screening • Osteoporosis screening (bone density study) – one every two consecutive calendar years for members age 65 and older	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Routine immunizations provided during an office visit	PPO: $20 copayment per office visit for adults (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $20 copayment per office visit for adults (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not Covered: *Routine physical checkups and related tests except those listed above*	*All charges*	*All charges*

Preventive care, children	You Pay — Standard Option	You Pay — High Option
Routine childhood immunizations recommended by the American Academy of Pediatrics for members under age 22	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)
Well-child office visits to a doctor for covered dependents up to age 18 Note: This benefit covers the office visit only, not any related services.	PPO: $10 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)	PPO: $10 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: *Routine testing not specifically listed as covered*	*All charges*	*All charges*

Maternity care	You Pay — Standard Option	You Pay — High Option
Complete maternity (obstetrical) care, including: • Pre-natal care • Delivery • Anesthesia • Post-natal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 14 for other circumstances such as extended stays for you or your baby. • You may remain in the hospital/birthing center up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon's services (delivery and newborn circumcision) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). • Newborn exams are payable under Section 5(a). • Newborn charges incurred as a result of illness, are considered expenses of the child, not the mother, and are subject to a separate precertification and separate coinsurance and/or copayments. • Maternity benefits will be paid at the termination of pregnancy.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under a self and family enrollment*	*All charges*	*All charges*

Family planning	You Pay — Standard Option	You Pay — High Option
Voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures, Section 5(b)) • Surgically implanted contraceptives (See Surgical procedures, Section 5(b)) • Intrauterine devices (IUDs)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
• Injectable contraceptive drugs (such as Depo-Provera) Note: We cover the related office visit under Diagnostic and treatment services (see page 24). Note: We cover oral contraceptive drugs under the Prescription drug benefit, Section 5(f).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not covered* Note: Certain prescription drugs for the treatment of infertility are covered under Prescription drug benefits. Call the Plan for a list of drugs that are covered for this service, or go to www.mhbp.com for a link to the list.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and gamete intrafallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank storage fees*	*All charges*	*All charges*

Allergy care	You Pay — Standard Option	You Pay — High Option
Testing, including materials	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)
Allergy serum	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Allergy injections (not including allergy serum)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction*	*All charges*	*All charges*

Treatment therapies	You Pay — Standard Option	You Pay — High Option
• Chemotherapy and radiation therapy for treatment of cancer. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 43-44. • Hyperbaric oxygen therapy • Treatment room • Observation room Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under the Prescription drug benefit, see Section 5(f).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
• Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy • Respiratory therapy • Inhalation therapy Note: Call us at 1-800-410-7778 for details about coverage and information about IV/infusion therapy, respiratory therapy and inhalation therapy PPO providers. Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Pharmacy charges for growth hormones are covered under the Prescription drug benefit, see Section 5(f).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Nothing	Nothing
Not covered: • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient admission* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)*	*All charges*	*All charges*

Rehabilitative therapies	You Pay — Standard Option	You Pay — High Option
Outpatient physical therapy, speech therapy, and occupational therapy Note: The annual $2,000 combined rehabilitative, chiropractic and alternative therapies maximum includes all covered services and supplies billed for these therapies. Note: For the purposes of this benefit, services and supplies provided by a doctor of osteopathy (D.O.) are included in the $2,000 benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided in a skilled nursing facility (SNF) is covered under this benefit if you are not confined in the SNF.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Charges billed after the Plan has paid the combined $2,000 rehabilitative, chiropractic and alternative treatment therapies maximum* • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Outpatient cardiac rehabilitation programs*	*All charges*	*All charges*
Hearing services (testing, treatment and supplies)		
One hearing aid per ear and related services are covered only when the hearing loss was caused by an accidental injury. The hearing aid must be purchased within 120 days of the accident and the patient must be covered by the Plan at the time of purchase. Note: The calendar year deductible applies.	All charges over $200 for one hearing aid per ear	All charges over $200 for one hearing aid per ear
Testing (non-routine) Note: The calendar year deductible applies.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: *Routine hearing tests, hearing aids, and related services when the hearing loss is not directly related to an accidental injury*	*All charges*	*All charges*

Vision services (testing, treatment and supplies)	You Pay — Standard Option	You Pay — High Option
One pair of eyeglasses or contact lenses to correct or treat an impairment directly caused by an accidental ocular injury or intraocular surgery (such as for cataracts). The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of purchase. Note: The calendar year deductible applies.	All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)	All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)
Not covered: • *Routine eye exams* • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises, refractions and related office visits* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care		
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under the surgery benefit. See Section 5(b).	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)
Not Covered: *Cutting, trimming and removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot except for the established diagnosis of diabetes*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You Pay — Standard Option	You Pay — High Option
Orthopedic and prosthetic devices (see Definitions — Section 12) when recommended by an MD or DO, including: • Artificial limbs and eyes, stump hose; • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy; • Internal prosthetic devices if billed by other than a hospital Note: Call us at 1-800-410-7778 for details about coverage and information about orthopedic and prosthetic PPO providers. Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: 10% of the Plan's allowance Non-PPO: 10% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 10% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports, heel pads and heel cups* • *Foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items*	*All charges*	*All charges*

Durable medical equipment	You Pay — Standard Option	You Pay — High Option
Durable Medical Equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment such as oxygen and dialysis equipment. We will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payer, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment. Under this benefit we also cover: • Wheelchairs; • Hospital beds; • Oxygen equipment; • Ostomy supplies (including supplies purchased at a pharmacy). Note: Call us at 1-800-410-7778 for details about coverage and information about durable medical equipment PPO providers. Any equipment billed by rehabilitative therapists or alternative medicine providers is covered under that benefit and subject to the combined annual maximum. Note: For those members who have Medicare Part B as their primary payer, diabetic supplies will be covered under this benefit. Note: See Treatment therapy for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Durable medical equipment – continued on next page

Durable medical equipment *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
Not Covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased or rented equipment* • *Safety, hygiene, convenience and exercise equipment* • *Household or vehicle modifications including seat, chair or van lifts; computer switchboard* • *Communication equipment including computer "story boards," "light talkers," and enhanced vision systems* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis)* • *Wigs or hair pieces* • *Motorized scooters, lifts, ramps, prone standers and other items that do not meet the DME definition* • *Dental appliances used to treat sleep apnea and/or temporomandibular joint dysfunction* • *Charges for educational/instructional advice on how to use the durable medical equipment* • *All rental charges above the purchase price or charges in excess of the secondary payer amount when we are the secondary payer* • *Customization or personalization of equipment* • *Blood pressure monitors*	*All charges*	*All charges*

Home health services – (nursing services)	You Pay — Standard Option	You Pay — High Option
A registered nurse (R.N.) or licensed practical nurse (L.P.N.) is covered for outpatient services when: • Prescribed by your attending physician (i.e., the physician who is treating your illness or injury) for outpatient services; • The physician indicates the length of time or number of visits the services are needed; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Services of a Christian Science Nurse are covered under this benefit.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $700 annual maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $700 annual maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $700 annual maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $700 annual maximum.
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after the Plan has paid $700 for covered nursing services*	*All charges*	*All charges*
Chiropractic		
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: $5 copayment per visit and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum (No deductible).	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum (No deductible).

Alternative treatment	You Pay — Standard Option	You Pay — High Option
Acupuncture Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient hospitalization* • *Thermography, biofeedback and related visits* • *Charges after the $2,000 combined rehabilitative, chiropractic therapies and alternative treatments annual maximum has been paid by the Plan* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see page 11.*	*All charges*	*All charges*
Educational classes and programs		
Smoking Cessation — Up to $100 for one smoking cessation program per member per lifetime Note: All benefits are paid directly to you. Smoking deterrents are covered under the Prescription drug benefit. See Section 5(f).	All charges over $100	All charges over $100
Not Covered: • *Self help or self management programs such as diabetic self management* • *Charges for educational/instructional advice on how to use durable medical equipment*	*All charges*	*All charges*

Section 5 (b). Surgical and anesthetic services provided by physicians and other health care professionals

IMPORTANT

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family) for Standard Option PPO services and $350 per person ($900 per family) for Standard Option non-PPO services; and $250 per person ($750 per family) for High Option PPO services and $300 per person ($900 per family) for High Option non-PPO services. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles (including the deductible waiver) and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a provider participating in the **First Health®** Network. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgery. Look in Section 5(c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- **PLEASE REMEMBER THAT ANY SURGICAL SERVICES THAT REQUIRE AN INPATIENT ADMISSION MUST BE PRECERTIFIED .** Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	High Option
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**You Pay – Standard Option**	**You Pay – High Option**
A comprehensive range of services, such as: • Operative procedures (performed by the primary surgeon) • Treatment of fractures, including casting; • Normal pre- and post-operative care by the surgeon; • Endoscopy procedures (diagnostic and surgical); • Biopsy procedures; • Electroconvulsive therapy; • Removal of tumors and cysts; • Correction of congenital anomalies (see Reconstructive surgery);	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
• Surgical treatment of morbid obesity — a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction; eligible members must be age 18 or over; • Insertion of internal prosthetic devices (See Section 5(a) — Orthopedic and prosthetic devices — for device coverage information); • Voluntary sterilization; • Surgically implanted contraceptives and intrauterine devices (IUDs); • Treatment of burns; • Correction of amblyopia & strabismus.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure: – PPO: the Plan's full allowance or – Non-PPO: the Plan's full allowance • For the secondary procedure: – PPO: one-half of the Plan's allowance or – Non-PPO: one-half of the Plan's allowance • For the tertiary procedure and any other subsequent procedures: – PPO: one-quarter of the Plan's allowance or – Non-PPO: one-quarter of the Plan's allowance	PPO: 10% of the Plan's allowance for the individual procedure Non-PPO: 30% of the Plan's allowance for the individual procedure and any difference between the Plan's allowance and the billed amount	PPO: 10% of the Plan's allowance for the individual procedure Non-PPO: 30% of the Plan's allowance for the individual procedure and any difference between the Plan's allowance and the billed amount

Surgical Procedures – continued on next page

Surgical procedures *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 50% of what it would pay a single surgeon for the same procedure(s).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeon Assistant surgical services provided by a qualified surgeon (M.D.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan will reduce its benefits for the assistant surgeon to 20% of the allowance for the surgery.	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.* • *Reversal of voluntary sterilization* • *Services of a standby surgeon* • *Routine treatment of conditions of the foot except for services rendered to established diabetics* • *Cosmetic surgery (See definition, page 41)* • *Radial keratotomy, laser and other refractive surgery* • *Assistant surgeon services from a non-physician provider, such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*All charges*	*All charges*

Reconstructive surgery	You Pay — Standard Option	You Pay — High Option
• Surgery to correct a functional defect; • Surgery to correct a condition caused by injury or illness if: The condition produces a major effect on the member's appearance, and The condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth, is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance of the breasts; • Treatment of any physical complications, such as lymphedemas. (See Prosthetic devices for coverage of breast prostheses and surgical bras and replacements.) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical* appearance *through a change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformation or sexual dysfunction*	*All charges*	*All charges*

Oral and maxillofacial surgery	You Pay — Standard Option	You Pay — High Option
Oral surgical procedures limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions); • Removal of stones from salivary ducts; • Excision of leukoplakia, tori or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Temporomandibular joint dysfunction surgery; • Other surgical procedures that do not involve the teeth or their supporting structures. Note: The related hospitalization (inpatient and outpatient) is covered if medically necessary. See Section 5(c).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Oral/dental implants and transplants;* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone (these procedures may be considered as covered dental procedures under the High Option Dental benefit);* • *Conservative treatment of temporomandibular joint dysfunction (TMJ);* • *Dental/oral surgical splints and stents.*	*All charges*	*All charges*

Organ/tissue transplants	You Pay — Standard Option	You Pay — High Option
National Transplant Program – The Plan participates in the **First Health®** National Transplant Program. Because transplantation is a highly specialized area, not all PPO hospitals are part of the National Transplant Program. **To qualify for this program, you or your physician must call us at 1-800-410-7778 as soon as the possibility of a transplant is discussed**. When you call, you will be given information about the program, including a list of participating facilities. To receive the highest level of benefits, you must choose one facility within the special network of transplant facilities. Transplant-related services must be received at the facility you choose in order to be covered under the National Transplant Program benefit. All transplant admissions must be precertified.		
Travel Benefit - the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 100 miles from the facility) up to $10,000 per transplant for the recipient and one companion (two companions if the recipient is a minor) and your organ donor, if applicable. For more information, contact us at 1-800-410-7778 before scheduling your pre-transplant evaluation.		
Donor Coverage - we cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan.		
Benefit Limitation: The maximum benefit for any organ/tissue transplant(s) is $1,000,000 per occurrence for the National Transplant Program, $200,000 per occurrence for PPO services or $100,000 per occurrence for non-PPO services, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, professional fees and donor expenses. To use the National Transplant Program, this must be your primary plan for payment of benefits. Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See section 5(c) for coverage of transplant-related services provided by a hospital.		
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas • Single lung • Double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Allogenic (donor) bone marrow transplants for chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form). *(covered transplants continued on next page)*	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
Covered transplants *(continued)* • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. • Autologous tandem bone marrow transplants for testicular and other germ cell tumors and for multiple myeloma. *Note: Pancreas (only) transplants are covered for insulin dependent (or Type 1) diabetes mellitus when exogenous treatment with insulin is deemed ineffective by the Plan. Note: Benefits will be paid at the PPO or Non-PPO level of benefits if no National Transplant Program provider is available. Note: Corneal transplants are not part of the National Transplant Program. Benefits will paid as described on page 38. Note: We cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.
Not covered: • *Expenses for services or supplies specifically excluded by the Plan, unless part of a treatment plan approved through the National Transplant Program* • *Donor screening tests and donor search expenses except those performed on the actual donor or those approved through the National Transplant Program* • *Travel, lodging and meal expenses not approved by the Plan* • *Services and supplies for or related to transplants not listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures*	*All charges*	*All charges*

Anesthesia	You Pay — Standard Option	You Pay — High Option
Professional services for the administration of anesthesia in hospital and out of hospital.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". If applicable, the calendar year deductible is $300 per person ($600 per family) for Standard Option PPO services and $350 per person ($900 per family) for Standard Option non-PPO services; and $250 per person ($750 per family) for High Option PPO services and $300 per person ($900 per family) for High Option non-PPO services.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a provider participating in the **First Health®** Network. When no PPO provider is available, non-PPO benefits apply. To help keep your out-of-pocket costs for coinsurance to a minimum, we encourage you to contact us for direction to PPO providers whenever possible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- Note: When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists may not all be preferred providers.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY**. Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You Pay	
	Standard Option	High Option
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**You Pay – Standard Option**	**You Pay – High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations, including birthing centers; • general nursing care; and • meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, our benefit will be based on the hospital's average charge for semiprivate accommodations. Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges.	PPO: Nothing Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: Nothing Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Pathology tests • Diagnostic laboratory and X-rays • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills directly we pay under Section 5(b). Note: The maximum benefit for any organ/tissue transplant(s) as described on pages 43-44 is $1,000,000 per occurrence for the National Transplant Program, $200,000 per occurrence for PPO services or $100,000 per occurrence for non-PPO services, which includes the following transplant-related expenses: pre-transplant evaluation, hospital care, professional fees and donor expenses. Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See section 5(b) for transplant-related professional services. Note: To use the National Transplant Program, this must be your primary plan for payment of benefits. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on pages 43-44. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. Note: Benefits for admission to Christian Science nursing facilities are limited to $30,000 per person per calendar year.	PPO: $200 copayment per admission and 15% of the Plan's allowance Non-PPO: $400 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: $100 copayment per admission and 15% of the Plan's allowance Non-PPO: $300 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Not covered: • *A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered.* • *Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day.* • *Custodial care; see Section 12: Definitions.* • *Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds.* • *Private inpatient nursing care.* • *Institutions that do not meet the definition of covered hospitals.* • *All charges after the Plan has paid $30,000 for services provided by a Christian Science nursing facility.*	*All charges*	*All charges*

Outpatient hospital, freestanding ambulatory surgical center, or clinic	You Pay — Standard Option	You Pay — High Option
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 23 hours, you need to precertify the admission. Note: For services billed by a surgeon, anesthetist or anesthesiologist see Section 5(b).	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory HealthCare (AAAHC), or which do not have Medicare certification as an ASC facility.*	*All charges*	*All charges*

Extended care benefit/skilled nursing care facility benefit	You Pay — Standard Option	You Pay — High Option
No benefit	*All charges*	*All charges*
Hospice care		
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $5,000 per lifetime for any combination of inpatient and outpatient services. If you use a PPO provider, your out-of-pocket expenses will be reduced.	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000
Not covered: • *Independent nursing, and homemaker services* • *Charges above $5,000*	*All charges*	*All charges*
Ambulance		
Local professional ambulance service when medically appropriate to the nearest hospital where treated and from that hospital to or from the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation.	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered • *Transportation to other than a hospital, hospice or urgent care medical facility*	*All charges*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family) for Standard Option PPO services and $350 per person ($900 per family) for Standard Option non-PPO services; and $250 per person ($750 per family) for High Option PPO services and $300 per person ($900 per family) for High Option non-PPO services;. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles (including the deductible waiver) and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a provider participating in the **First Health®** Network. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury? An accidental injury is a bodily injury sustained through external and accidental means, such as broken bones, animal bites, poisonings and injuries to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury/Medical emergency	**You Pay – Standard Option**	**You Pay – High Option**
If you receive outpatient care for your accidental injury or medical emergency in a hospital emergency room or urgent care center, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery Note: We pay inpatient hospital benefits if you are admitted. Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time the services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: $150 copayment per occurrence (if admitted to the hospital, copayment is waived) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Accidental injury – continued on next page

Accidental injury/Medical emergency *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Non-surgical physician services provided in a doctor's office for your accidental injury or medical emergency.	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)
Ambulance		
Local professional ambulance service when medically appropriate to the nearest hospital where treated and from that hospital to or from the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition warrants immediate evacuation.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered • *Transportation to other than a hospital, hospice or urgent care medical facility*	*All charges*	*All charges*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

You may choose to get care Out-of-Network or In-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits of other illnesses and conditions. If In-Network care is not authorized, Out-of-Network benefits will be paid.

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and/or clinically appropriate.
- The Mental health and substance abuse benefits calendar year deductible is $300 per person ($600 per family) for Standard Option PPO services and $350 per person ($900 per family) for Standard Option non-PPO services; and $250 per person ($750 per family) for High Option PPO services and $300 per person ($900 per family) for High Option non-PPO services. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. This calendar year deductible is in addition to the calendar year deductible for medical services and the calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES**. See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 55.

IMPORTANT

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	High Option
Managed In-Network Benefits	**You Pay – Standard Option**	**You Pay – High Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Managed In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Outpatient professional services, including individual or group therapy by providers approved by the Managed In-Network vendor. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	$20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible)	$20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible)

Managed In-Network Benefits – continued on next page

Managed In-Network Benefits *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
• Inpatient professional services	10% of the Plan's allowance	10% of the Plan's allowance
• Electroshock therapy and laboratory procedures • Diagnostic tests including psychological testing	10% of the Plan's allowance	10% of the Plan's allowance
• Services provided by a hospital or other inpatient facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$200 copayment per admission, nothing for room and board and 15% of the Plan's allowance for hospital ancillary services (No deductible)	$100 copayment per admission, nothing for room and board and 15% of the Plan's allowance for hospital ancillary services (No deductible)
Not covered: Services we have not approved	*All charges*	*All charges*
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.		

Preauthorization — To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and the following network authorization process:

Call the Plan at 1-800-410-7778 to be referred to the Managed Network vendor. If you do not call, the charges will be processed as Out-of-Network benefits.

Network Limitation — **If you do not obtain an approved treatment plan we will provide only Out-of-Network benefits**

Out-of-Network benefits for services and supplies provided by Out-of-Network providers or services and supplies not approved by us	You Pay – Standard Option	You Pay – High Option
Outpatient professional services to treat mental health/substance abuse Note: One day in partial hospitalization/day treatment program is considered as one outpatient visit.	30% of the Plan's allowance for up to 20 visits and any difference between our allowance and the billed amount. All charges after 20 visits.	30% of the Plan's allowance for up to 20 visits and any difference between our allowance and the billed amount. All charges after 20 visits.
Inpatient professional services to treat mental health/substance abuse	30% of the Plan's allowance after the mental health/substance abuse calendar year deductible, and any difference between our allowance and the billed amount.	30% of the Plan's allowance after the mental health/substance abuse calendar year deductible, and any difference between our allowance and the billed amount.
Electroshock therapy, diagnostic tests and laboratory procedures	30% of the Plan's allowance after the mental health/substance abuse calendar year deductible, and any difference between our allowance and the billed amount.	30% of the Plan's allowance after the mental health/substance abuse calendar year deductible, and any difference between our allowance and the billed amount.
Inpatient care to treat mental health includes ward or semiprivate accommodations and other hospital charges	$400 copayment per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.	$300 copayment per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	$400 copayment per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.	$300 copayment per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.
Not covered Out-of-Network: • *Services, that in the Plan's judgment, are not medically necessary* • *Services by pastoral, marital, drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools, licensed residential treatment centers or halfway houses or members of their staffs*	*All charges*	*All charges*

Precertification The medical necessity of your **admission** to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about out-of-pocket maximum for In-Network benefits.
- Section 9, *Filing a claim for covered services*, for information about submitting Out-of-Network claims.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 58.
- Please remember all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible for prescription drugs is separate from the annual deductible for medical benefits and separate from the annual deductible for mental health and substance abuse. We added "(No deductible)" to show when the calendar year prescription drug deductible does not apply.
- The Calendar Year prescription drug deductible is $350 per person ($700 per family) for Standard Option. The Plan will waive all of the prescription deductible as described on page 58 for members who have Medicare Parts A and B as their primary coverage. Generic drugs are not subject to the prescription drug deductible.
- The Calendar Year prescription drug deductible is $200 per person ($400 per family) for High Option. The Plan will waive all of the prescription deductible as described on page 58 for members who have Medicare Parts A and B as their primary coverage. Generic drugs are not subject to the prescription drug deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription?** A physician or other covered provider acting within the scope of their license.
- **Where you can obtain them?** You may fill the prescription at a **First Health®** Rx participating pharmacy ("network" or "network pharmacy"), a non-network pharmacy or by mail for certain drugs. We pay a higher level of benefits when you use a network pharmacy.

  Network pharmacy – Present your Plan identification card at a network pharmacy to purchase prescription drugs. You must have the pharmacy file the claim electronically for you in order to receive the network pharmacy level benefit. Call 1-800-410-7778 or check the electronic directory via www.mhbp.com to locate the nearest network pharmacy.

  Non-Network pharmacy – You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See: When you have to file a claim.

  Mail order – To obtain more information about the mail order drug program, order refills, check order status and request additional mail services envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call the Plan at 1-800-410-7778 or visit our Web site at www.mhbp.com.

- **We administer an open formulary.** We administer a Formulary Management Program designed to control costs for you and the Plan. The formulary is updated periodically and includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. The tiers or categories include:

  Generic Drug Category includes primarily generic drugs;
  Preferred Drug Category includes preferred brand name drugs;
  Non-Preferred Drug Category includes non-preferred brand name drugs.

  Occasionally, drugs may change from one category to another category during the year; this can affect your copayment amount. We will attempt to notify you when this occurs.

- Please note: Information about the program and a copy of the formulary was included with your identification card. When you need a prescription, share the formulary with your provider and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary, we may have restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits and preauthorization. To request a copy of our current formulary, call us at 1-800-410-7778 or visit our Web site, www.mhbp.com.
- **Why use generic drugs?** A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. The U.S Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.

- **There are dispensing limitations.** All prescriptions will be limited to a 30-day supply for retail and a 90-day supply for mail order. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.

  Specialty drugs, including biotech drugs, require special handling and close monitoring, are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders. These drugs require preauthorization to determine medical necessity and appropriate utilization. In addition to specialty drugs, we require preauthorization for certain classes of drugs, including, but not limited to: growth hormones; replacement enzymes; physical adjuncts; immunomodulators; drugs used to treat Attention Deficit Disorder and narcolepsyoncologic agents; endothelin receptor antagonists; neuromuscular blocking agents; and monoclonal antibodies to IGE. Call us at 1-800-410-7778 if you have any questions regarding preauthorization, quantity limits, or other issues.

  We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. You can call us while you are in the pharmacy or in advance at 1-800-410-7778 to request the accommodation.

- **The Plan conducts Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail-order program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or **First Health**® Rx may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. For more information about this program, call us at 1-800-410-7778.
- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, mail your prescription receipts to: The Mail Handlers Benefit Plan, Prescription Drug Claims, Box 23824, Tucson, AZ 85734. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of drugstore and NDC number (included on the bill).

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

Note: All drugs may not be available through the mail order program. Some of the drug classes that may not be available are: narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgment limit the dispensing amount to less than 90 days. In addition, some injectables may not be available through mail-order services. However, these excluded drugs are covered under the retail prescription drug program. For questions about the mail-order prescription drug program or to inquire about specific drugs or medications, please call 1-800-410-7778.

This Plan has two levels of reimbursement for retail prescription drug claims. One is for prescriptions filled at a network pharmacy for claims filed electronically or for prescriptions filled at a foreign pharmacy while you are living outside the United States. The second is for prescriptions filled at a non-network pharmacy or other vendor, or when you reside in the United States and choose to submit a paper claim. It is in your best interest to have your prescription filled at a network pharmacy that files your claims electronically. If you do not file electronically and do not live overseas, your reimbursement will be reduced to 50% of the allowable charges. Remember to show your Mail Handlers Benefit Plan ID card with the **First Health**® Rx logo to receive increased benefits and the convenience of having your claims filed electronically for you.

Prescription drug benefits begin on the next page

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and accessories	**You Pay – Standard Option**	**You Pay – High Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail (for certain prescription drugs): • Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy. • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy). • Insulin and related testing material. • Oral contraceptives. (Implants and implant insertions are covered under Surgical Benefits.) • Diaphragms. • Smoking deterrents. For questions about the prescription drug program, or to obtain a copy of our current formulary, please call 1-800-410-7778 or visit our Web site at www.mhbp.com.	Network pharmacies or prescriptions filled by foreign pharmacies: $10 per Generic drug (No deductible)/ $30 per Preferred brand name drug/$45 per Non-Preferred brand name drug Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan's allowance for the prescription and any difference between our allowance and the billed amount Network pharmacies with Medicare: $10 per Generic drug /$30 per Preferred brand name drug/$45 per Non-Preferred brand name drug (No deductible) Mail Order: $10 per Generic drug (No deductible)/$40 per Preferred brand name drug/$55 per Non-Preferred brand name drug Mail Order with Medicare: $10 per Generic drug/$40 per Preferred brand name drug/$55 per Non-Preferred brand name drug (No deductible)	Network pharmacies or prescriptions filled by foreign pharmacies: $10 per Generic drug (No deductible)/ $25 per Preferred brand name drug /$40 per Non-Preferred brand name drug Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan allowance for the prescription and any difference between our allowance and the billed amount Network pharmacies with Medicare: $10 per Generic drug /$25 per Preferred brand name drug/$40 per Non-Preferred brand name drug (No deductible) Mail Order: $10 per Generic drug (No deductible)/ $30 per Preferred brand name drug/$45 per Non-Preferred brand name drug Mail Order with Medicare: $10 per Generic drug/$30 per Preferred brand name drug/$45 per Non-Preferred brand name drug (No deductible)

Covered medications and accessories – continued on next page

Covered medications and accessories *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Prescriptions written by a non-covered provider.* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them.* • *Total parenteral nutrition (TPN) products and related services.* • *Nonprescription drugs or medicines.* • *Anorexiants or weight loss medications.* • *Erectile dysfunction drugs.* • *Drugs and supplies when another insurance plan or payer provides benefits, regardless of actual payment, for these services/supplies except Medicare Part B covered diabetic supplies.* • *Any amount in excess of the cost of the generic drug when a generic is available and the physician has not specified that the pharmacist dispense the brand name drug.*	*All charges*	*All charges*

Section 5 (g). Special features

Special Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
First Health® OnCall	**First Health**® OnCall provides integrated health benefit services including a national PPO network, clinical management services, a national transplant program, a care support program with Internet visits, round-the-clock benefits support, pharmacy network and plan administration. A brief description of the specialized maternity program, care support and Internet visits is included below. If you have questions about any of the programs, your benefits or would like general health information, call us at 1-800-410-7778, 24 hours a day, 7 days a week.
– Specialized Maternity Program	The specialized maternity program is a voluntary service designed to assist you during your pregnancy by identifying high-risk pregnancies to promote positive outcomes for the mother and baby and to assist in coordinating cost-effective care. To access the program, call us at 1-800-410-7778 during your first trimester. A nurse case manager will ask questions about your general health and medical history. If appropriate, a case manager will follow your case, inform you about specialists and/or facilities when applicable, and coordinate communication among you and the health care providers involved in your care.
– **First Health**® Care Support Program	A voluntary program providing a variety of disease management services designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of conditions that can be managed through this program are: diabetes, asthma and heart failure. We use medical and/or pharmacy claims data as well as interactions with you and your physician(s) to determine if you may benefit from this program. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call us at 1-800-410-7778, 24 hours a day, 7 days a week.
– Internet visit	If you have a chronic illness and are receiving care support services, you and your PPO network physician may be able to help manage your condition using Internet visits. This service allows you to communicate with your physician, privately and securely, via the Internet. You are the only one allowed to initiate an Internet visit. You will be able to log on to a password-protected Web site and send a non-urgent message with pertinent information or questions regarding your condition to your physician. In turn, your physician will respond to your message, which may verify that your current treatment plan is working well, state what changes need to be made to your treatment plan, give answers to your questions, or recommend that you schedule an office visit. Using Internet visits does not affect your ability to seek a face-to-face consultation with your physician, and the Plan will always respect the physician-patient relationship. We limit the number of Internet visits to 24 per year. Please note: To use this service, this must be your primary plan for payment of benefits, you must have an established relationship with the treating physician for your illness and your physician must be participating in the network at the time of the Internet visit. If you have any questions or would like to register for this service, call us at 1-800-410-7778, at any time, day or night. **Note: Services provided under this benefit are not subject to the FEHB disputed claims process.**

Section 5 (h). Dental benefits for High Option only

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no deductible for High Option Dental Benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.
- High Option pays actual charges up to the amounts specified in the schedule of dental allowances for covered dental procedures, up to a maximum benefit of $800 per person and $1,600 per family per calendar year.
- For covered dental procedures not shown, the Plan will pay, subject to the limits provided, amounts consistent with procedures which are shown.
- Dental PPO — The Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. If you use a PPO dentist, you only pay the difference between the network rate and the Plan benefit. To locate a PPO dentist in your area or for information about the Plan's benefits, call 1-800-410-7778 or visit the Plan's Web site www.mhbp.com.
- The Plan is unable to return dental X-rays. Remind your dentist not to submit X-rays.
- If in the construction of a denture or any prosthetic dental appliance, the patient and the dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the benefit provided will be limited to the amount payable for the standard procedures.
- Charges for crowns, bridges, and dentures are usually incurred when they are ordered. The Plan pays benefits to cover such charges even if the enrollee later rejects the denture or appliance.

Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. Inpatient hospitalizations must be precertified by the Plan. See Section 5(c) for inpatient hospital benefits.

The following is a partial list of dental plan benefit amounts.

IMPORTANT

Dental benefits

ADA Code	Service	We Pay (Plan benefit)	You Pay
	DIAGNOSTIC		
00120	Periodic oral examination (limit one per year)	$ 7.50	All charges above Plan benefit.
00210	X-rays, intraoral, complete series including bitewings (limit one per year)	22.00	All charges above Plan benefit.
00220	X-rays, intraoral, periapical — first film	3.25	All charges above Plan benefit.
00230	X-rays, intraoral, periapical — each additional film	2.25	All charges above Plan benefit.
00240	X-rays, intraoral, occlusal film	7.50	All charges above Plan benefit.
00270	X-rays, bitewing, single film	2.75	All charges above Plan benefit.
00290	X-rays, posterior-anterior or lateral skull and facial bone survey	13.00	All charges above Plan benefit.
00330	X-rays, panoramic film	22.00	All charges above Plan benefit.

Dental benefits – continued on next page

Dental benefits *(continued)*

ADA Code	Service	We Pay (Plan benefit)	You Pay
	PREVENTIVE (dollar amount shown is limit per calendar year)		
01110	Prophylaxis, adult (age 13 and over)	$ 14.25	All charges above Plan benefit.
01120	Prophylaxis, child (through age 12)	12.00	All charges above Plan benefit.
01203	Fluoride application, topical, child	7.50	All charges above Plan benefit.
01204	Fluoride application, topical, adult	7.50	All charges above Plan benefit.
01351	Sealant, per tooth	7.50	All charges above Plan benefit.
01510	Space maintainer, fixed, unilateral (limited to age 18 and under)	34.00	All charges above Plan benefit.
	RESTORATIVE (includes liners, bases and local anesthesia)		
02140	One surface, permanent	$ 13.00	All charges above Plan benefit.
02150	Two surfaces, permanent	20.75	All charges above Plan benefit.
02160	Three surfaces, permanent	27.50	All charges above Plan benefit.
02951	Reinforcement pins, each pin	8.25	All charges above Plan benefit.
	ENDODONTICS (includes local anesthesia)		
03110	Pulp cap, direct	$ 16.50	All charges above Plan benefit.
03310	Root canal therapy, one canal	96.75	All charges above Plan benefit.
03320	Root canal therapy, two canals	136.25	All charges above Plan benefit.
03330	Root canal therapy, three canals	178.00	All charges above Plan benefit.
03410	Apicoectomy	55.00	All charges above Plan benefit.
	PERIODONTICS (includes local anesthesia)		
04320	Provisional splinting	$ 81.25	All charges above Plan benefit.
04341	Periodontal scaling and root planing (per quadrant)	13.00	All charges above Plan benefit.
04910	Periodontal maintenance procedures	13.00	All charges above Plan benefit.

Dental benefits – continued on next page

Dental benefits *(continued)*

ADA Code	Service	We Pay (Plan benefit)	You Pay
	CROWN AND BRIDGE (includes local anesthesia)		
02510	Inlay, metallic, one surface	$ 68.00	All charges above Plan benefit.
02710	Crown, resin (laboratory)	108.75	All charges above Plan benefit.
02720	Crown, resin with high noble metal	178.00	All charges above Plan benefit.
02740	Crown, porcelain with ceramic substrate	136.25	All charges above Plan benefit.
02750	Crown, porcelain fused to high noble metal	178.00	All charges above Plan benefit.
02752	Crown, porcelain fused to noble metal	178.00	All charges above Plan benefit.
02790	Crown, full cast, high noble metal	149.50	All charges above Plan benefit.
02950	Core buildup, including any pins	27.50	All charges above Plan benefit.
02920	Recement crown	27.50	All charges above Plan benefit.
02952	Cast post and core, in addition to crown	68.00	All charges above Plan benefit.
02954	Prefabricated post and core, in addition to crown	34.00	All charges above Plan benefit.
02980	Crown repair	13.00	All charges above Plan benefit.
	PONTICS (includes local anesthesia)		
06210	Cast high noble metal	$ 82.50	All charges above Plan benefit.
06240	Porcelain fused to high noble metal	136.25	All charges above Plan benefit.
	DENTURES (prosthetics)		
05110	Complete denture, maxillary (including necessary adjustments within 6 months)	$ 239.75	All charges above Plan benefit.
05120	Complete denture, mandibular (including necessary adjustments within 6 months)	239.75	All charges above Plan benefit.
05130	Immediate denture, maxillary	272.50	All charges above Plan benefit.
05140	Immediate denture, mandibular	272.50	All charges above Plan benefit.
05211	Partial denture, maxillary, resin base	217.75	All charges above Plan benefit.
05510	Repair, complete denture, base	20.75	All charges above Plan benefit.
05520	Repair, complete denture, repair or replace teeth (each tooth)	9.75	All charges above Plan benefit.
05630	Repair, partial denture, repair or replace clasp	40.50	All charges above Plan benefit.
05640	Repair, partial denture, repair or replace teeth (each tooth)	13.00	All charges above Plan benefit.
05650	Add tooth, partial denture	34.00	All charges above Plan benefit.
05660	Add clasp, partial denture	40.50	All charges above Plan benefit.
05710	Rebase, complete denture, maxillary	68.00	All charges above Plan benefit.

Dental benefits – continued on next page

Dental benefits *(continued)*

ADA Code	Service	We Pay (Plan benefit)	You Pay
	ORAL SURGERY (includes local anesthesia)		
04210	Gingivectomy or gingivoplasty (per quadrant)	$ 102.50	All charges above Plan benefit.
04260	Osseous surgery, including flap entry and closure (per quadrant)	137.50	All charges above Plan benefit.
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal	15.00	All charges above Plan benefit.
07210	Surgical extraction of erupted tooth	23.00	All charges above Plan benefit.
07285	Biopsy of oral hard tissue	34.00	All charges above Plan benefit.
07310	Alveoloplasty in conjunction with extraction (per quadrant)	44.00	All charges above Plan benefit.
07450	Removal of odontogenic cyst or tumor/lesion, up to 1.25 cm	66.00	All charges above Plan benefit.
07510	Incision and drainage of abscess, intraoral soft tissue	13.00	All charges above Plan benefit.
07960	Frenulectomy (frenectomy or frenotomy), separate procedure	61.50	All charges above Plan benefit.
	MISCELLANEOUS SERVICES		
09110	Palliative treatment of dental pain, minor procedure	$ 7.50	All charges above Plan benefit.
09220	General anesthesia — first 30 minutes	8.75	All charges above Plan benefit.
09221	General anesthesia — each additional 15 minutes	4.38	All charges above Plan benefit.
09310	Consultation by other than attending dentist	20.75	All charges above Plan benefit.

Note: For services rendered due to accidental injury to sound natural teeth, see Section 5(d).

What is not covered

- *Charges related to orthodontia*
- *Oral hygiene instruction*
- *Denture replacements (if benefits were provided by this Plan within the last five years)*
- *Temporary dental services*
- *Dental/oral surgical splinting*
- *Dental implants or related surgical benefits*
- *Orthotics, splints, stents and other occlusal appliances used to treat temporomandibular joint dysfunction and/or sleep apnea*
- *Conservative treatment of temporomandibular joint dysfunction (TMJ)*

Section 6. Consumer Option Benefits – OVERVIEW

(*See page 9 for how our benefits changed this year and page 130 for a benefits summary.)*

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 9; they apply to the benefits in the following subsections. To obtain claim forms, claim filing advice, or more information about your Consumer Option benefits, contact us at 1-800-694-9901 or at our Web site at www.mhbp.com.

The MHBP Consumer Option focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. The source of this control is either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), available only when you are enrolled in a "high deductible health plan" (HDHP), such as the MHBP Consumer Option. When you enroll in the MHBP Consumer Option, MHBP will establish an HSA or an HRA for you and will credit a portion of your health plan premium into your account.

MHBP Consumer Option covers PPO preventive care in full and you can use your HSA or HRA to pay for other, non-preventive care. When you meet your annual deductible (HSA) or your Member Responsibility (HRA), we provide Traditional Health Coverage that works like a regular preferred provider organization (PPO) plan. If you don't use up your HSA or HRA for the year, you can roll over the remaining balance to the next year.

The MHBP Consumer Option includes four key components:

This component covers 100% for preventive care for adults and children if you use a network provider. The covered services include office visits/exams, immunizations and screenings and are fully described in Section 6(a). You do not have to meet your annual deductible in order to receive these benefits. Non-PPO preventive care is not covered.

Health Savings Account (HSA)

A Health Savings Account (HSA) is an individual savings account owned by you and funded by you and the MHBP that can help pay for future qualified medical expenses for you and your dependents. By law, health savings accounts are available to members who can not be claimed as a dependent on someone else's tax return, have not received VA benefits within the previous three months, and do not have Medicare or another health plan, other than another high-deductible health plan. You own your HSA, so the funds can go with you if you happen to change plans or employment.

In 2005, for each month you are eligible for an HSA premium pass through, MHBP will contribute up to $83.33 per month ($1,000 per year) for a Self Only enrollment or $166.66 per month ($2,000 per year) for a Self and Family enrollment into your HSA while you remain enrolled. You can make additional tax-free contributions to your HSA up to the difference between the Consumer Option annual deductible and the MHBP contribution. In 2005, you can contribute up to $1,250 for a Self Only enrollment and up to $2,500 for a Self and Family enrollment. Excess contributions are subject to a 6% excise tax, unless such contributions are removed from the account by April 15, after the plan year ends. See page 73 for an explanation of catch-up contributions for individuals age 55 and older.

Features of an HSA include:

- Your HSA is administered by JPMorgan Chase Bank
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or change health plans
- When you need it, funds up to the actual HSA balance are available

Note: Disputes between JPMorgan Chase Bank and the enrollee are not subject to the disputed claims process.

Health Reimbursement Arrangement (HRA)

For members who aren't eligible for an HSA, are enrolled inMedicare or have another health plan, MHBP will provide and administer an HRA. Like an HSA, an HRA allows you to accumulate savings to pay for qualified out-of-pocket medical expenses. The differences are that an HRA does not earn interest, does not allow personal contributions to your account, and does not allow reimbursements for non-medical expenses. Funds in an HRA are forfeited if you leave Federal employment or change health plans.

In 2005, MHBP will credit your HRA up to $1,000 per year for a Self Only enrollment or $2,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

Features of an HRA include:

- Administered by MHBP
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any family members covered under this HDHP
- Unused credits carry over from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans

After you have met your annual deductible, we pay benefits under the Traditional Health Coverage described in Sections 6(c) through 6(h). Your cost for covered services is generally a fixed copayment amount for PPO care and 40% of the Plan's allowance for non-PPO care. The Consumer Option also features a Catastrophic Protection Benefit (see Section 4).

Covered services include:

Section 6(c). Medical services and supplies provided by physicians and other health care professionals

Section 6(d). Surgical and anesthesia services provided by physicians and other health care professionals

Section 6(e). Hospital services, other facilities and ambulance

Section 6(f). Emergency services/Accidents

Section 6(g). Mental health and substance abuse benefits

Section 6(h). Prescription drug benefits

Section 6(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars. There is also Care Support and a 24-hour nurse advisory service.

Section 6 (a). PPO preventive care

IMPORTANT

Here are some important things you should keep in mind about these PPO preventive care benefits:

- Under the Consumer Option, we pay 100% for the preventive care services listed in this Section as long as you use a network (PPO) provider.
- For all other covered expenses, please see Sections 6(c-h) – Traditional health coverage.
- The Consumer Option calendar year deductible does not apply to PPO preventive care benefits.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay
Preventive care, adult	
One annual routine office visit and examination for members age 18 and older	Nothing
Routine screenings, limited to: • Mammograms for women age 35 and older - From age 35 to 39 – one during this five year period - From age 40 to 64 – one every calendar year - At age 65 and older – one every two consecutive calendar years • Pap smear – one per calendar year for women age 18 and older Note: The office visit is covered if pap test is received on the same day. • Prostate Specific Antigen (PSA) test — one per calendar year for men age 40 and older • Colorectal cancer screenings: - Fecal occult blood (stool) test — one per calendar year for members age 40 and older - Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older - Colonoscopy – one every 10 years for members age 50 and older • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members	Nothing

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine screenings (continued): • Chlamydial infection screening • Osteoporosis screening (bone density study) – one every two consecutive calendar years for members age 65 and older • Smoking cessation treatment -- up to $100 for one smoking cessation program per member per lifetime Note: All benefits are paid directly to you. Smoking deterrents are covered under the Prescription drug benefit. See Section 6(h). • Routine immunizations provided during an office visit	Nothing
Not Covered: *Routine physical checkups and related tests except those listed above*	*All charges*
Preventive care, children	
Routine childhood immunizations recommended by the American Academy of Pediatrics for members under age 22	Nothing
Well-child office visits to a doctor for covered dependents up to age 18	Nothing
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members	Nothing
Not Covered: *Routine testing not specifically listed as covered*	*All charges*

Section 6 (b). Savings – Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA)		
Savings Features	**Health Savings Account (HSA)**	**Health Reimbursement Arrangement (HRA)** (provided when you are ineligible for an HSA)
Administrator	The Plan will establish an HSA for you with JPMorgan Chase Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). JPMorgan Chase Bank 270 Park Avenue New York, NY 10017-2070 212-270-6000	MHBP is the administrator for your HRA: Mail Handlers Benefit Plan PO Box 25403 Tucson, AZ 85734 1-800-694 9901
Fees	Set-up fee is paid by the MHBP	None
Eligibility	To have an HSA: • You must be enrolled in the MHBP Consumer Option • You must not have other health insurance coverage (except for certain "permitted" insurance plans, such as dental or vision care plans or another high-deductible health plan) • You must not be enrolled in Medicare Part A and/or Part B • You may not be claimed as a dependent on someone else's federal tax return You must complete and return all banking paperwork associated with the establishment of your account	To have an HRA: • You must be enrolled in the MHBP Consumer Option • When you enroll in the MHBP Consumer Option and do not qualify for an HSA, an HRA will be established for you
Tax advantages	• Tax-free health plan deposits • Tax-deductible enrollee deposits • Tax-free distributions for qualified medical expenses • Tax-free interest earned on the account	• Tax-free health plan deposits • Tax-free distributions for qualified medical expenses
Funding	A portion of your monthly health plan premium is deposited to your HSA each month. Contributions are based on the effective date of your enrollment in the HDHP. For 2005, monthly contributions are: • $83.33 for a Self Only enrollment • $166.66 for a Self and Family enrollment. Eligibility for contributions will be determined on the first day of the month and will be prorated for length of enrollment.	The entire amount of your HRA will be available to you upon your enrollment. For 2005, your HRA credit is: • $1,000 for a Self Only enrollment • $2,000 for a Self and Family enrollment. Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment.

Savings Features	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) (provided when you are ineligible for an HSA)
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible. For 2005, the maximum annual contributions are: • $2,250 for a Self Only enrollment • $4,500 for a Self and Family enrollment.	The full HRA credit will be available on the effective date of your enrollment, subject to proration based on your length of enrollment. The HRA does not earn interest. Enrollee contributions to an HRA are not permitted.
Self Only	For each month you are eligible for HSA contributions, MHBP will make a premium pass through contribution of $83.33. You may make a contribution of $104.17 for each month of eligibility, up to $1,250 for a full year. You can make your contributions at any time before April 15 after the plan year ends.	Enrollee contributions to an HRA are not permitted.
Self and Family	For each month you are eligible for HSA contributions, MHBP will make a premium pass through contribution of $166.66. You may make a contribution of $208.33 for each month of eligibility, up to $2,500 for a full year. You can make your contributions at any time before April 15 after the plan year ends.	Enrollee contributions to an HRA are not permitted.
If you choose to contribute to your HSA	• You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. • You may roll over funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). • HSAs earn tax-free interest (does not affect your annual maximum contribution).	Enrollee contributions to an HRA are not permitted.
Accessing your funds	You can access your HSA by the following methods: • Debit card issued by JPMorgan Chase Bank • Manual HSA distribution form	For qualified medical expenses under your HDHP, you or your provider will be automatically reimbursed when claims are submitted to the MHBP Consumer Option. For expenses not covered by the HDHP, such as orthodontia, you can request a reimbursement form by phone or obtain one on-line at www.mhbp.com .

Savings Features	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) (provided when you are ineligible for an HSA)
Distributions/withdrawals		
Medical expenses	You can use the available funds in your HSA to pay the out-of-pocket medical expenses for yourself, your spouse or your dependents even if they are not covered by the HDHP. Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established. For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2005. See IRS Publication 502 for a complete list of eligible expenses. (http://www.irs.gov/pub/irs-pdf/p502.pdf)	The available credit in your HRA will be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See Availability of funds below for information on when funds are available in the HRA. See IRS Publication 502 for a complete list of eligible expenses. (http://www.irs.gov/pub/irs-pdf/p502.pdf)
Non-medical expenses • **Under age 65**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.	Distributions will not be made for anything other than non-reimbursed qualified medical expenses
• **Age 65 or over**	When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty.	Distributions will not be made for anything other than non-reimbursed qualified medical expenses, except that Medicare premiums are reimbursable.
Availability of funds	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • MHBP receives record of your enrollment and initially establishes your HSA account with JPMorgan Chase Bank by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • JPMorgan Chase Bank sends out HSA paperwork for the enrollee to complete, and receives the completed paperwork. After JPMorgan Chase Bank receives the completed paperwork from the enrollee, the enrollee can withdraw funds for expenses incurred on or after the date the HSA was initially established.	The entire amount of your HRA will be available to you upon your enrollment in this Plan.
Account owner	FEHB Enrollee	MHBP

Savings Features	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) (provided when you are ineligible for an HSA)
Portability	You own your HSA and can take it with you when you leave Federal employment or change health plans.	If you retire and remain in the MHBP Consumer Option, you may continue to use and accumulate credits in your HRA. If you terminate Federal employment or change health plans, only eligible expenses incurred while covered under the MHBP Consumer Option will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

HSAs

Is the "premium pass through" to my HSA considered taxable income?

"Premium pass-through" contributions by the MHBP are not considered taxable income.

Can I contribute to my HSA?

Yes. All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make a lump sum contribution at any time, in any amount up to an annual maximum limit. Others can also make contributions to your HSA on your behalf. If you (or someone on your behalf) contribute a lump-sum, you can claim the total amount contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2005, you may contribute up to $600 in "catch-up" contributions. Catch-up contributions in later years increase up to a maximum of $1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled for Medicare. Additional details are available on the IRS Web site at **www.irs.gov**.

Rate of interest earned

Depending on how you choose to invest your HSA savings, the interest rate and payment of interest will vary. Contact JPMorgan Chase Bank for more details on the investment options available to you.

What happens to my HSA if I leave my health plan or job?

You own your account, so you keep your HSA even if you change health plans, leave Federal employment, enroll for Medicare, or any of the other events which may make you ineligible for further contributions to your HSA. Even when you are not eligible to make contributions to your HSA, you may request withdrawals.

What happens to my HSA if I die?

Your HSA would pass to your named beneficiary. If you do not have a named beneficiary, the money is disbursed to your estate and is taxable. Additional details are available on the IRS Web site at **www.irs.gov**.

To make the most of your Health Savings Account, you should:

- Use generic prescriptions whenever possible.
- Use the network providers whenever possible.
- Use your debit card at network pharmacies. Do not use your debit card at the point of service when visiting a health care provider. Use your debit card only after network discounts are applied by MHBP and you receive an explanation of benefits (EOB) with your financial responsibility described.

What expenses can I pay for with my HSA?

You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, and health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you become Medicare-enrolled, you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare-enrolled.

For the complete list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at **www.irs.gov** and click on "Forms and Publications."

Non-qualified health expenses

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

Tracking your HSA balance

You will receive a periodic statement that shows contributions and withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

Minimum reimbursements from your HSA

You can request reimbursement in any amount.

HRAs

How do I know if I qualify for an HRA?

If you don't qualify for an HSA when you enroll, or later become ineligible for an HSA, the MHBP will establish an HRA for you.

HRA and HSA differences

Please review the chart at the beginning of this Section which details the differences. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and

HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

Traditional Health Coverage

IMPORTANT

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- PPO preventive care listed in Section 6(a) is covered at 100% and does not count against your Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).
- The Consumer Option provides coverage for both PPO and non-PPO providers. The non-PPO benefits are the regular benefits under the Traditional Health Coverage. PPO benefits apply only when you use a provider participating in the **First Health®** Network. When a PPO provider is not available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be PPO providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 11 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY**. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

IMPORTANT

Benefit Description	You Pay
Note: The calendar year deductible applies to all benefits in this Section.	
Member Responsibility before Traditional Health Coverage begins	**You Pay**
Traditional Health Coverage benefits begin after covered eligible expenses total $2,250 for Self Only or $4,500 for Self and Family each calendar year. When you have a Health Savings Account, you are responsible for the annual deductible before your Traditional Health Coverage begins. When you have a Health Reimbursement Arrangement and your HRA has been exhausted, you are responsible to pay your Member Responsibility before your Traditional Health Coverage begins. For additional information, see Section 6(b), *Savings*.	$2,250 per person or $4,500 per family for PPO and non-PPO covered services

Section 6(c). Medical services and supplies provided by physicians and other health care professionals	You Pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $15 copayment per visit, including testing performed and billed in conjunction with the visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians during a hospital stay	PPO: Nothing Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: $15 copayment per visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
First Health® Lab Program You can use this voluntary program for covered lab tests. You show your Mail Handlers Benefit Plan identification card and ask your doctor to send your lab order to Quest Diagnostics. As long as Quest Diagnostics does the testing and bills us directly, you will not have to file any claims. To find a location near you, call 1-800-377-7220, or visit our Web site at www.mhbp.com.	Nothing Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.

Lab, X-ray and other diagnostic tests – continued on next page

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Lab, X-ray and other diagnostic tests *(continued)*	
Not Covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, including: • Pre-natal care • Delivery • Anesthesia • Post-natal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 14 for other circumstances such as extended stays for you or your baby. • You may remain in the hospital/birthing center up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon's services (delivery and newborn circumcision) the same as for illness and injury. See Hospital benefits and Surgery benefits. • Newborn charges incurred as a result of illness, are considered expenses of the child, not the mother, and are subject to a separate precertification and separate inpatient deductibles, coinsurance and/or copayments. Maternity benefits will be paid at the termination of pregnancy.	PPO: Nothing Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under a self and family enrollment*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Family planning	
Voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures, Section 6(d)) • Surgically implanted contraceptives (See Surgical procedures, Section 6(d)) • Intrauterine devices (IUDs) • Injectable contraceptive drugs (such as Depo-Provera) Note: We cover oral contraceptive drugs under the Prescription drug benefit, Section 6(h).	PPO: $15 copayment per office visit; $50 per outpatient surgical procedure Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered* Note: Certain prescription drugs for the treatment of infertility are covered under Prescription drug benefits. Call the Plan for a list of drugs that are covered for this service, or go to www.mhbp.com for a link to the list.	PPO: $15 copayment per visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and gamete intrafallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank storage fees*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Allergy care	
Testing, including materials	PPO: $15 copayment per visit , including testing performed and billed in conjunction with the visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Allergy serum	PPO: $15 copayment Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Allergy injections (not including allergy serum)	PPO: $15 copayment per visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy for treatment of cancer. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 90-91. • Hyperbaric oxygen therapy • Treatment room • Observation room Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under the Prescription drug benefit, see Section 6(h).	PPO: $15 copayment per visit for services provided in a physician's office or clinic; $25 copayment per outpatient hospital visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies – continued on next page

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Treatment therapies (continued)	
• Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy • Respiratory therapy • Inhalation therapy Note: Call us at 1-800-410-7778 for details about coverage and information about IV/infusion therapy, respiratory therapy and inhalation therapy PPO providers. Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Pharmacy charges for growth hormones are covered under the Prescription drug benefit, see Section 6(h).	PPO: $15 copayment per office, clinic or home visit; $25 copayment per outpatient hospital visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Rabies shots and related services	PPO: $15 copayment per office visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Rehabilitative therapies	
Outpatient physical therapy, speech therapy, and occupational therapy Note: The annual $2,000 combined rehabilitative, chiropractic and alternative therapies maximum includes all covered services and supplies billed for these therapies. Note: For the purposes of this benefit, services and supplies provided by a doctor of osteopathy (D.O.) are included in the $2,000 benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided in a skilled nursing facility is covered under this benefit.	PPO: $15 copayment per visit and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Charges billed after the Plan has paid the combined $2,000 rehabilitative, chiropractic and alternative treatment therapies maximum* • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Outpatient cardiac rehabilitation programs*	*All charges*
Not covered: • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient admission* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 6(d)*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Hearing services (testing, treatment, and supplies)	
One hearing aid per ear and related services are covered only when the hearing loss was caused by an accidental injury. The hearing aid must be purchased within 120 days of the accident and the patient must be covered by the Plan at the time of purchase.	PPO: $15 copayment per visit and all charges over $200 for one hearing aid per ear Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount. All charges over $200 for one hearing aid per ear
Testing (non-routine)	PPO: $15 copayment per visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Routine hearing tests, hearing aids, and related services when the hearing loss is not directly related to an accidental injury*	*All charges*
Vision services (testing, treatment, and supplies)	
One pair of eyeglasses or contact lenses to correct or treat an impairment directly caused by an accidental ocular injury or intraocular surgery (such as for cataracts). The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of purchase.	PPO: $15 copayment per visit and all charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount. All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)
Not covered: • *Routine eye exams* • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises, refractions and related office visits* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	**You Pay**
Foot care	
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under the surgery benefit. See Section6(d).	PPO: $15 copayment per visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: *Cutting, trimming and removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot except for the established diagnosis of diabetes*	*All charges*
Orthopedic and prosthetic devices	
Orthopedic and prosthetic devices (see Definitions — Section 12) when recommended by an MD or DO, including: • Artificial limbs and eyes, stump hose; • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy; • Internal prosthetic devices if billed by other than a hospital Note: Call us at 1-800-410-7778 for details about coverage and information about orthopedic and prosthetic PPO providers. Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: Nothing Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports, heel pads and heel cups* • *Foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment such as oxygen and dialysis equipment. We will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payer, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment. Under this benefit we also cover: • Wheelchairs; • Hospital beds; • Oxygen equipment; • Ostomy supplies (including supplies purchased at a pharmacy). Note: Call us at 1-800-410-7778 for details about coverage and information about durable medical equipment PPO providers. Any equipment billed by rehabilitative therapists or alternative medicine providers is covered under that benefit and subject to the combined annual maximum. Note: For those HRA members who have Medicare Part B as their primary payer, diabetic supplies will be covered under this benefit. Note: See Treatment therapies for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment.	PPO: Nothing Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) – continued on next page

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	**You Pay**
Durable medical equipment (DME) *(continued)*	
Not Covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased or rented equipment* • *Safety, hygiene, convenience and exercise equipment* • *Household or vehicle modifications including seat, chair or van lifts; computer switchboard* • *Communication equipment including computer "story boards," "light talkers," and enhanced vision systems* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis)* • *Wigs or hair pieces* • *Motorized scooters, lifts, ramps, prone standers and other items that do not meet the DME definition* • *Dental appliances used to treat sleep apnea and/or temporomandibular joint dysfunction* • *Charges for educational/instructional advice on how to use the durable medical equipment* • *All rental charges above the purchase price or charges in excess of the secondary payer amount when we are the secondary payer* • *Customization or personalization of equipment* • *Blood pressure monitors*	*All charges*
Home health services – (nursing services)	
A registered nurse (R.N.) and licensed practical nurse (L.P.N.) is covered for outpatient services when: • Prescribed by your attending physician (i.e., the physician who is treating your illness or injury) for outpatient services; • The physician indicates the length of time or number of visits the services are needed; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Services of a Christian Science Nurse are covered under this benefit.	PPO: $15 copayment per visit and all charges after the Plan has paid the $700 annual maximum. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $700 annual maximum.
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after the Plan has paid $700 for covered nursing services*	*All charges*

Section 6(c). Medical services and supplies provided by physicians and other health care professionals *(continued)*	You Pay
Chiropractic	
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: $15 copayment per visit and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum
Alternative treatment	
Acupuncture Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: $15 copayment per visit and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient hospitalization* • *Thermography, biofeedback and related visits* • *Charges after the $2,000 combined rehabilitative, chiropractic therapies and alternative treatments annual maximum has been paid by the Plan* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see page 11.*	*All Charges*

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals	You Pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures (performed by the primary surgeon) • Treatment of fractures, including casting; • Normal pre- and post-operative care by the surgeon; • Endoscopy procedures (diagnostic and surgical); • Biopsy procedures; • Electroconvulsive therapy; • Removal of tumors and cysts; • Correction of congenital anomalies (see Reconstructive surgery); • Surgical treatment of morbid obesity — a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction; eligible members must be age 18 or over; • Insertion of internal prosthetic devices (See Orthopedic and prosthetic devices for device coverage information); • Voluntary sterilization; • Surgically implanted contraceptives and intrauterine devices (IUDs); • Treatment of burns; • Correction of amblyopia & strabismus.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount.
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure: – PPO: the Plan's full allowance or – Non-PPO: the Plan's full allowance • For the secondary procedure: – PPO: one-half of the Plan's allowance or – Non-PPO: one-half of the Plan's allowance • For the tertiary procedure and any other subsequent procedures: – PPO: one-quarter of the Plan's allowance or – Non-PPO: one-quarter of the Plan's allowance	PPO: Nothing for physician services performed inpatient or outpatient hospital /ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures – continued on next page

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals *(continued)*	**You Pay**
Surgical procedures *(continued)*	
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 50% of what it would pay a single surgeon for the same procedure(s).	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeon Assistant surgical services provided by a qualified surgeon (M.D.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan will reduce its benefits for the assistant surgeon to 20% of the allowance for the surgery.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.* • *Reversal of voluntary sterilization* • *Services of a standby surgeon* • *Routine treatment of conditions of the foot except for services rendered to established diabetics* • *Cosmetic surgery (See definition, page 88)* • *Radial keratotomy, laser and other refractive surgery* • *Assistant surgeon services from a non-physician provider, such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*All charges*

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals *(continued)*	You Pay
Reconstructive surgery	
• Surgery to correct a functional defect; • Surgery to correct a condition caused by injury or illness if: The condition produces a major effect on the member's appearance, and The condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance of the breasts; • Treatment of any physical complications, such as lymphedemas. (See Prosthetic devices for coverage of breast prostheses and surgical bras and replacements.) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through a change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformation or sexual dysfunction*	*All charges.*

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals *(continued)*	You Pay
Oral and maxillofacial surgery	
Oral surgical procedures limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions); • Removal of stones from salivary ducts; • Excision of leukoplakia, tori or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Temporomandibular joint dysfunction surgery; • Other surgical procedures that do not involve the teeth or their supporting structures. Note: The related hospitalization (inpatient and outpatient) is covered if medically necessary. See Section 6(e).	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Oral/dental implants and transplants;* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone;* • *Conservative treatment of temporomandibular joint dysfunction (TMJ);* • *Dental/oral surgical splints and stents.*	*All charges*

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals *(continued)*	You Pay
Organ/tissue transplants	
National Transplant Program – The Plan participates in the **First Health®** National Transplant Program. Because transplantation is a highly specialized area, not all PPO hospitals are part of the National Transplant Program. **To qualify for this program, you or your physician must call us at 1-800-410-7778 as soon as the possibility of a transplant is discussed**. When you call, you will be given information about the program, including a list of participating facilities. To receive the highest level of benefits, you must choose one facility within the special network of transplant facilities. Transplant-related services must be received at the facility you choose in order to be covered under the National Transplant Program benefit. All transplant admissions must be precertified.	
Travel Benefit - the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 100 miles from the facility) up to $10,000 per transplant for the recipient and one companion (two companions if the recipient is a minor) and your organ donor, if applicable. For more information, contact us at 1-800-410-7778 before scheduling your pre-transplant evaluation.	
Donor Coverage - we cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan.	
Benefit Limitation: The maximum benefit for any organ/tissue transplant(s) is $1,000,000 per occurrence for the National Transplant Program, $200,000 per occurrence for PPO services or $100,000 per occurrence for non-PPO services, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, professional fees and donor expenses. To use the National Transplant Program, this must be your primary plan for payment of benefits. Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Services provided by a hospital or other facility and ambulance services for coverage of transplant-related services provided by a hospital.	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas • Single lung • Double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Allogenic (donor) bone marrow transplants for chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form). *(covered transplants continued on next page)*	National Transplant Program: Nothing for inpatient services; and all charges over $1,000,000. PPO: Nothing for inpatient services; and all charges over $200,000. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.

Organ/tissue transplants – continued on next page

Section 6(d). Surgical and anesthetic services provided by physicians and other health care professionals *(continued)*	You Pay
Organ/tissue transplants *(continued)*	
Covered transplants *(continued)* • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. • Autologous tandem bone marrow transplants for testicular and other germ cell tumors and for multiple myeloma. Note: Corneal transplants are not part of the National Transplant Program. Benefits will paid as described on page 86. *Note: Pancreas (only) transplants are covered for insulin dependent (or Type 1) diabetes mellitus when exogenous treatment with insulin is deemed ineffective by the Plan. Note: Benefits will be paid at the PPO or Non-PPO level of benefits if no National Transplant Program provider is available. Note: We cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.	National Transplant Program: Nothing for inpatient services; and all charges over $1,000,000. PPO: Nothing for inpatient services; and all charges over $200,000. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.
Not covered: • *Expenses for services or supplies specifically excluded by the Plan, unless part of a treatment plan approved through the National Transplant Program* • *Donor screening tests and donor search expenses except those performed on the actual donor or those approved through the National Transplant Program* • *Travel, lodging and meal expenses not approved by the Plan* • *Services and supplies for or related to transplants not listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures*	*All charges*
Anesthesia	
Professional services for the administration of anesthesia in hospital and out of hospital.	PPO: Nothing for services performed on an inpatient basis or outpatient hospital /ASC; $15 copayment when performed in a physician's office. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

Section 6(e). Services provided by a hospital or other facility, and ambulance services	You Pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations, including birthing centers; • general nursing care; and • meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, our benefit will be based on the hospital's average charge for semiprivate accommodations. Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Pathology tests • Diagnostic laboratory and X-rays • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills directly we pay under Section6(d). Note: The maximum benefit for any organ/tissue transplant(s) as described on pages 90-91 is $1,000,000 per occurrence for the National Transplant Program, $200,000 per occurrence for PPO services or $100,000 per occurrence for non-PPO services, which includes the following transplant-related expenses: pre-transplant evaluation, hospital care, professional fees and donor expenses. Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Section 6(d) for transplant-related professional services. Note: To use the National Transplant Program, this must be your primary plan for payment of benefits. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on pages 90-91. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. Note: Benefits for admission to Christian Science nursing facilities are limited to $30,000 per person per calendar year.	PPO: $75 copayment per day, up to a maximum of $750 per admission Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Section 6(e). Services provided by a hospital or other facility, and ambulance services *(continued)*	You Pay
Inpatient hospital *(continued)*	
Not covered: • *A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered.* • *Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day.* • *Custodial care; see Section 12: Definitions.* • *Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds.* • *Private inpatient nursing care.* • *Institutions that do not meet the definition of covered hospitals.* • *All charges after the Plan has paid $30,000 for services provided by a Christian Science nursing facility*	*All charges*
Outpatient hospital, freestanding ambulatory surgical center, or clinic	
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 23 hours, you need to precertify the admission. Note: For services billed by a surgeon or anesthetist, see Section 6(d).	PPO: $25 copayment per occurrence for non-surgical related services; $150 copayment per occurrence for outpatient surgery Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory*	*All charges*
HealthCare (AAAHC), or which do not have Medicare certification as an ASC facility.	

Section 6(e). Services provided by a hospital or other facility, and ambulance services *(continued)*	**You Pay**
Extended care benefit/skilled nursing care facility benefit	
No benefit	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. We pay $5,000 per lifetime for any combination of inpatient and outpatient services. If you use a PPO provider, your out-of-pocket expenses will be reduced.	PPO: $25 copayment per outpatient visit; $75 per day up to a maximum of $750 per admission for inpatient services. All charges after the Plan has paid $5,000. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid $5,000.
Not covered: • *Independent nursing, and homemaker services* • *Charges above $5,000.*	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate to the nearest hospital where treated and from that hospital to or from the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital or urgent care medical facility*	*All charges*

Section 6(f). Emergency services/accidents	
What is an accidental injury? An accidental injury is a bodily injury sustained through external and accidental means, such as broken bones, animal bites, poisonings and injuries to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.	
Accidental injury/Medical emergency	
If you receive outpatient care for your accidental injury or medical emergency in a hospital emergency room or urgent care center, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery Note: We pay inpatient hospital benefits if you are admitted. Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time the services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: $50 copayment per occurrence (if admitted to the hospital, copayment is waived) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services provided in a doctor's office for your accidental injury or medical emergency.	PPO: $15 copayment per visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	
Local professional ambulance service when medically appropriate to the nearest hospital where treated and from that hospital to or from the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital or urgent care medical facility*	*All charges*

Section 6(g). Mental health and substance abuse benefits	You Pay
In-network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Managed In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	$15 copayment per visit
• Outpatient diagnostic tests including psychological testing and laboratory procedures	$15 copayment per visit
• Inpatient professional services • Electroshock therapy	Nothing
• Services provided by a hospital or other inpatient facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$75 copayment per day, up to a maximum of $750 per admission
Not covered: Services we have not approved	*All charges*
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	

Preauthorization — To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and the following network authorization process:

Call the Plan at 1-800-410-7778 to be referred to the Managed Network vendor. If you do not call, the charges will be processed as Out-of-Network benefits.

Network Limitation — **If you do not obtain an approved treatment plan we will provide only Out-of-Network benefits**

Mental health and substance abuse benefits – continued on next page

Section 6(g). Mental health and substance abuse benefits *(continued)*	You Pay
Out-of-network benefits	
Outpatient professional services to treat mental health/substance abuse Note: One day in partial hospitalization/day treatment program is considered as one outpatient visit.	40% of the Plan's allowance for up to 20 visits and any difference between our allowance and the billed amount. All charges after 20 visits.
Inpatient professional services to treat mental health/substance abuse	40% of the Plan's allowance and any difference between our allowance and the billed amount
Electroshock therapy, diagnostic tests and laboratory procedures	40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient care to treat mental health includes ward or semiprivate accommodations and other hospital charges	40% of the Plan's allowance and any difference between our allowance and the billed amount for up to 45 days per calendar year. All charges for services rendered after the covered 45 days.
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	40% of the Plan's allowance and any difference between our allowance and the billed amount for up to 45 days per calendar year. All charges for services rendered after the covered 45 days.
Not covered Out-of-Network: • *Services, that in the Plan's judgment, are not medically necessary* • *Services by pastoral, marital, drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools, licensed residential treatment centers or halfway houses or members of their staffs*	*All charges*

Precertification The medical necessity of your **admission** to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about out-of-pocket maximum for In-Network benefits.
- Section 9, *Filing a claim for covered services*, for information about submitting Out-of-Network claims.

Section 6(h). Prescription drug benefits

There are important features about your prescription drug program you should be aware of. These include:

- **Who can write your prescription?** A physician or other covered provider acting within the scope of their license.
- **Where you can obtain them?** You may fill the prescription at a **First Health®** Rx participating pharmacy ("network" or "network pharmacy"), a non-network pharmacy or by mail for certain drugs. We pay a higher level of benefits when you use a network pharmacy.

  Network pharmacy – Present your Plan identification card at a network pharmacy to purchase prescription drugs. You must have the pharmacy file the claim electronically for you in order to receive the network pharmacy level benefit. Call 1-800-410-7778 or check the electronic directory via www.mhbp.com to locate the nearest network pharmacy.

  Non-Network pharmacy – Not covered, except for prescriptions provided by Veterans Administration (VA), Department of Defense (DoD), and Indian Health Service (IHS) facilities.

  Mail order – To obtain more information about the mail order drug program, order refills, check order status and request additional mail services envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call the Plan at 1-800-410-7778 or visit our Web site at www.mhbp.com.

- **We administer an open formulary.** We administer a Formulary Management Program designed to control costs for you and the Plan. The formulary is updated periodically and includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. The tiers or categories include:

  Generic Drug Category includes primarily generic drugs;
  Preferred Drug Category includes preferred brand name drugs;
  Non-Preferred Drug Category includes non-preferred brand name drugs.

  Occasionally, drugs may change from one category to another category during the year; this can affect your copayment amount. We will attempt to notify you when this occurs.

- Please note: Information about the program and a copy of the formulary was included with your identification card. When you need a prescription, share the formulary with your provider and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary, we may have restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits and preauthorization. To request a copy of our current formulary, call us at 1-800-410-7778 or visit our Web site, www.mhbp.com.
- **Why use generic drugs?** A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. The U.S Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.
- **There are dispensing limitations.** All prescriptions will be limited to a 30-day supply for retail and a 90-day supply for mail order. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.

  Specialty drugs, including biotech drugs, require special handling and close monitoring, are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders. These drugs require preauthorization to determine medical necessity and appropriate utilization. In addition to specialty drugs, we require preauthorization for certain classes of drugs, including, but not limited to: growth hormones; replacement enzymes; physical adjuncts; immunomodulators; drugs used to treat Attention Deficit Disorder and narcolepsyoncologic agents; endothelin receptor antagonists; neuromuscular blocking agents; and monoclonal antibodies to IGE. Call us at 1-800-410-7778 if you have any questions regarding preauthorization, quantity limits, or other issues.

  We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. You can call us while you are in the pharmacy or in advance at 1-800-410-7778 to request the accommodation.

Prescription drug benefits – continued on next page

Section 6(h). Prescription drug benefits *(continued)*

- **The Plan conducts Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail-order program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or **First Health**® Rx may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. For more information about this program, call us at 1-800-410-7778.
- **When you have to file a claim.** If you purchase prescriptions at a network pharmacy and your forget your ID card or the pharmacy is unable to file your claim electronically, mail your prescription receipts to: The Mail Handlers Benefit Plan, Prescription Drug Claims, Box 23824, Tucson, AZ 85734. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of drugstore and NDC number (included on the bill).

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

Note: All drugs may not be available through the mail order program. Some of the drug classes that may not be available are: narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgment limit the dispensing amount to less than 90 days. In addition, some injectables may not be available through mail-order services. However, these excluded drugs are covered under the retail prescription drug program. For questions about the mail-order prescription drug program or to inquire about specific drugs or medications, please call 1-800-410-7778.

This Plan has two levels of reimbursement for retail prescription drug claims. One is for prescriptions filled at a network pharmacy for claims filed electronically **or for prescriptions filled at a foreign pharmacy while you are living outside the United States**. **The second is for prescriptions filled when you reside in the United States and choose to submit a paper claim**. It is in your best interest to have your prescription filled at a network pharmacy that files your claims electronically. If you do not file electronically and do not live overseas, **your reimbursement will be reduced to 50%** of the allowable charges. Remember to show your Mail Handlers Benefit Plan ID card with the **First Health**® Rx logo to receive increased benefits and the convenience of having your claims filed electronically for you.

Covered medications and accessories	You Pay
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail (for certain prescription drugs): • Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy. • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy). • Insulin and related testing material. • Oral contraceptives. (Implants and implant insertions are covered under Surgical Benefits.) • Diaphragms. • Smoking deterrents. For questions about the prescription drug program, or to obtain a copy of our current formulary, please call 1-800-410-7778 or visit our Web site at www.mhbp.com.	Network pharmacies or prescriptions filled by foreign pharmacies: $10 per Generic drug/ $25 per Preferred brand name drug/$40 per Non-Preferred brand name drug; for prescriptions or refills up to a 30-day supply. Non-network pharmacies: Not covered Note: Benefits for services billed by VA, DoD and IHS facilities will be paid at 60% of the Plan's allowance Mail Order: $20 per Generic drug/$50 per Preferred brand name drug/$80 per Non-Preferred brand name drug; for prescriptions or refills up to a 90 day supply. Medicare retail and mail order: Benefits will be paid as described above

Prescription drug benefits – continued on next page

Section 6(h). Prescription drug benefits *(continued)*	**You Pay**
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Prescriptions written by a non-covered provider.* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them.* • *Total parenteral nutrition (TPN) products and related services* • *Nonprescription drugs or medicines.* • *Anorexiants or weight loss medications.* • *Erectile dysfunction drugs.* • *Drugs and supplies when another insurance plan or payer provides benefits, regardless of actual payment, for these services/supplies except Medicare Part B covered diabetic supplies.* • *Any amount in excess of the cost of the generic drug when a generic is available and the physician has not specified that the pharmacist dispense the brand name drug.*	*All charges*

Section 6 (i). Health education resources and account management tools

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Health education resources	The Mail Handlers Benefit Plan takes the health and safety of its members seriously. Visit www.mhbp.com and select **Health Education** for online resources which include: • Live Well: Link to articles covering disease prevention the proper use of medications, nutrition and exercise. • One Minute Health Checks: Members can take a brief introductory quiz and link to related topics. • The Medical Library: Link to articles about treatment options, common symptoms and their causes and child development. • Health Risk Assessment: Members can assess their overall health profile using a comprehensive evaluation tool. • Patient safety information.
Account management tools	HSA • You will receive a monthly statement from JPMorgan Chase Bank outlining your transactional account balance and activity for the month. • You will receive a quarterly statement from JPMorgan Chase Bank outlining your investment account balance and interest earned. • You may also access your account on-line through www.mhbp.com • Members may also contact Member Services to review account transactions and balances and where appropriate, be connected with JPMorgan Chase Bank to receive information on additional services, such as reporting lost or stolen cards, receiving advice on investment options or making changes to investment options. HRA • A complete payment history is available on-line through www.mhbp.com • You will also receive an explanation of benefits (EOB) after every claim

Section 6 (i). Health education resources and account management tools *(continued)*	
Special features	**Description**
Round-the-clock support/ care support	You may call MHBP's toll-free number at 1-800-410-7778, at any time, day or night, to: initiate the certification or notification process; obtain assistance in locating network providers; obtain general health care information; or have your questions about health care issues answered. A nurse will provide you with information about your condition, self-care and, if necessary, suggest the names of network providers from whom you may seek health care. This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. This service is not meant to replace physician care. If you require medical care, please be sure to see your physician or practitioner. Through interactions with you and your physician, or based on your pharmacy and/or medical claims data, you may be contacted by First Health to participate in the care support program. Care support is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of illnesses that may be managed through this program are diabetes, asthma and high risk pregnancies. A case manager will work closely with you to provide you with educational information about your condition, treatment plan or medication support. As always, your final treatment plan will be decided between you and your physician. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call MHBP at 1-800-410-7778.

Section 7. Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium**, and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

The MHBP Federal Dental and Vision Plans

Two programs, one for dental care and one for vision care, are available to ALL Federal and Postal employees and annuitants eligible for FEHBP and their family members. Help plug the gaps in your FEHBP coverage with comprehensive benefits at affordable group rates. The sooner you enroll, the sooner your coverage starts!

They're brought to you by the Mail Handlers Benefit Plan, **but you don't have to be an MHBP member to get them.** Choose either one — or both!

The MHBP Federal Dental Plan – the dental care benefits you need at affordable group rates

Your benefits will increase every year for three years:

First year:

- 100% first-year PPO benefit, no deductible, for covered Preventive services like cleanings, exams and x-rays
- 70% first-year PPO benefit, for covered Basic services like fillings, root canals and oral surgery

Second year:

- PPO benefit for Basic services **increases** to 80%
- **Add** coverage for Major services like crowns and bridges – PPO benefits 50%

Third year:

- **Add** coverage for Orthodontic treatment for dependent minors – 50% coverage up to $1,000 per person lifetime benefit

And more ...

- Only a $50 annual deductible per person, limited to $150 per family
- Up to $1,000 in benefits per person every year, up to $3,000 per family
- Over 65,000 PPO locations to choose from nationwide
- Benefits available for Non-PPO providers, too!

Right from the start of your enrollment, you can receive benefits up to $1,000 per person every year, and $3,000 per family. So enrolling now pays off.

The MHBP Federal Vision Plan - For wellness care, annual exams, eyeglasses, contacts and more

When you use VSP's nationwide network:

- Eye exams & lenses every 12 months for just a $10 copayment each
- Pays up to $100 for frames (every 24 months) or contact lenses (every 12 months)
- Discounted rates for laser vision correction
- Access to the nation's largest network of eyecare doctors — VSP — with no claim forms required
- Out-of-network benefits too

Enroll in either plan – or both – any time! You can start coverage before January!

Get all the details at **www.mhbp.com,** and enroll too! Or call toll-free: **1-800-254-0227.**

Non-FEHB benefits available to Plan Members – continued on next page

Non-FEHB benefits available to Plan Members *(continued)*

- **HearPO** hearing care and hearing aid discount program provides Plan enrollees and eligible family members substantial savings from the following leading manufacturers: GN ReSound, Siemens, Unitron, Phonak, Rexton, and Electone.

  Your benefits include:

  - Access to over 280 hearing aid choices starting as low as $549 per aid
  - Analog and digital products available from industry leading manufacturers
  - Savings on all styles of hearing instruments including completely in the canal, in the ear, and behind the ear
  - Savings on all levels of technology, including the newest programmable and digital instruments
  - Access to more than 1,300 HearPO credentialed locations across the United States
  - Discounts on hearing aid repairs
  - A 60-day trial period with a money-back guarantee and no restocking fees
  - Comprehensive follow-up services at no charge for one year
  - Free demonstrations of the latest available technologies
  - Testing performed by licensed hearing care professionals

  To assure you of the highest quality care, the HearPO network is comprised exclusively of licenced audiologists and Board Certified hearing instrument specialists. These caring, experienced providers are ready to help you with your hearing health needs.

  To access your hearing benefit from the HearPO Network, or for a listing of HearPO providers in your area, call HearPO at **1-888-HEARING (1-888-432-7464)**. Please remember to identify yourself as an MHBP member.

- **Vision One Eyecare Program**® provides Plan enrollees and eligible family members the ability to obtain $35 eyeglass examinations and discounts of up to 60% on eyeglasses and contact lenses from Vision One providers. For more information concerning the Vision One Eyecare Program® or to locate a participating Vision One center near you, visit the Plan's Web site, www.mhbp.com, or call 1-800-804-4384.

- **Laser Vision Correction Program** provides Plan enrollees and eligible family members the ability to take advantage of substantial savings (typical savings between $100 and $800 for two eyes) when using The Cole LASIK Network. This program offers hundreds of locations nationwide. For more information about the program or to locate a participating doctor, call 1-888-705-2020.

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Section 8. General Exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as covered, we will not provide benefits for it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services and supplies for which there would be no charge if the covered individual had no health insurance coverage;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy, penile prosthesis;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services and supplies furnished by household members or immediate relatives, such as spouse, parents, grandparents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services, drugs and supplies associated with care that is not covered, though they may be covered otherwise (e.g., Inpatient Hospital Benefits are not payable for non-covered cosmetic surgery);
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 20), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge) (see page 21), or State premium taxes however applied;
- Services, drugs and supplies for weight control or treatment of obesity, except surgery for documented morbid obesity;
- Educational, recreational or milieu therapy, whether in or out of the hospital;
- Services and supplies for cosmetic purposes, except as provided under Surgical Benefits/Reconstructive Surgery;
- Biofeedback;
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Eyeglasses, contact lenses and hearing aids, except as provided under Sections 5(a) and 6(c);
- Orthotics, splints, stents and appliances used to treat temporomandibular joint dysfunction and/or sleep apnea;
- Custodial care (see definition) or domiciliary care;
- Travel, even if prescribed by a doctor, except as provided under the National Transplant Program or Ambulance Benefit;
- Handling Charges/Administrative Charges or late charges, including interest, billed by providers of care;
- Charges for medical records not requested by us;
- Fees for missed appointments; and
- Services and/or supplies not listed as covered in this brochure.

Section 9. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800-410-7778, or visit our Web site at www.mhbp.com

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. All claims should be completed in ink or type that is readable by an optic scanner. For claims questions and assistance, call us at 1-800-410-7778.

When you must file a claim — such as when you receive services overseas or when another group health plan is primary — submit it on the HCFA-1500 or a claim form that includes the information shown below. Claims should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name, address and provider or employer tax identification of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer, such as the Medicare Summary Notice (MSN), with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the patient's attending physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. For inpatient hospital services, the exchange rate will be based on the date of admission. For all other services, we will apply the exchange rate for the date the services were rendered.
- Overseas providers (those outside the continental United States, Alaska and Hawaii) will be paid at the PPO level of benefits for covered services.
- All foreign claim payments will be made directly to the enrollee except for services rendered to beneficiaries of the United States Department of Defense third party collection program.
- Canceled checks, cash register receipts, or balance due statements are not acceptable.

  After completing a claim form and attaching proper documentation, send medical and dental claims to:

  The Mail Handlers Benefit Plan
  P.O. Box 24503
  Tucson, AZ 85734

- Claims for prescription drugs and supplies that are not ordered through the mail order prescription drug program or not purchased from and electronically filed with a participating **First Health**® Rx network pharmacy must include receipts with the NDC number (included on the bill), name of drug or supply, date, charge and name and address of the pharmacy.

  After completing a claim form and attaching proper documentation send prescription claims to:

  The Mail Handlers Benefit Plan
  Prescription Drug Claims
  P.O. Box 23824
  Tucson, AZ 85734

Note: Do not include any medical or dental claims with your claims for drug benefits.

If all the required information is not included on the claim, the claim may be delayed or denied.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide year-end statements.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. It is your responsibility to make sure your claims are filed within the timely filing deadline. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

Claims that are submitted by the hospital will be paid directly to the hospital (with the exception of foreign claims). You may authorize direct payment to any other provider of care by signing the assignment of benefits section on the claim form, or by using the assignment form furnished by the provider of care. The provider of care's Tax Identification Number must accompany the claim. The Plan reserves the right to make payment directly to you, and to decline to honor the assignment of payment of any health benefits claim to any person or party.

Claims submitted by PPO hospitals and medical providers will be paid directly to the hospital or provider.

Note: Benefits for services provided at Department of Defense, Veterans Administration or Indian Health Service facilities will be paid directly to the facility.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

The Plan, its medical staff and/or an independent medical review, determines whether services, supplies and charges meet the coverage requirements of the Plan (subject to the disputed claims procedure described in Section 10, *The disputed claims process*). We are entitled to obtain medical or other information — including an independent medical examination — that we feel is necessary to determine whether a service or supply is covered.

Section 10. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies — including a request for preauthorization/prior approval.

Step	Description

1 Ask us in writing to reconsider our initial decision. You must:

(a) Write to us within 6 months from the date of our decision; and

(b) Send your request to us at: The Mail Handlers Benefit Plan, P.O. Box 24503, Tucson, AZ 85734; and

(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:

(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

(b) Write to you and maintain our denial — go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group II, 1900 E Street NW, Washington, D.C. 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

The disputed claims process *(continued)*

Step	Description
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. **Note: If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-410-7778 and we will expedite our review; or (b) We denied your initial request for care or preauthorization/prior approval, then: • If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or • You may call OPM's Health Insurance Group II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 11. Coordinating Benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays medical expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The combined payment from both plans may be less than (but will not exceed) the entire amount billed by the provider.

The provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan — You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1-800-410-7778 or check www.mhbp.com.

We waive some costs if the Original Medicare Plan is your primary payer— We will waive some out-of-pocket costs, as follows:

High Option and Standard Option

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and Part B (Medical Insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services both we and Medicare Part B cover depend on whether your physician accepts Medicare assignment for the claim.

When Original Medicare is primary, all or part of your Plan deductibles, copayments and coinsurance will be waived as indicated below:

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance abuse benefits and nursing benefits.
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance abuse services.
- When Medicare Parts A and B are primary, the Plan will waive the calendar year deductible for prescription drugs purchased at a retail pharmacy and through the mail order prescription drug program for both High Option and Standard Option.

Note: The Plan will not waive the copayments and coinsurance for retail or mail order prescription drugs.

Consumer Option

- If your physician accepts Medicare assignment, then you pay nothing if you have unused credit available under your HRA to pay the difference between the Medicare approved amount and Medicare's payment. After your HRA is exhausted and your Member Responsibility has been met, you pay either the difference between the Medicare approved amount and Medicare's payment or your copayment amount, whichever is less.

Note: The Plan will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payer.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
	The primary payer for the individual with Medicare is…	
A. When you - or your covered spouse - are age 65 or over and have Medicare and you…	**Medicare**	**This Plan**
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and…		✓
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and… • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	✓
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and… • This Plan was the primary payer before eligibility due to ESRD • Medicare was the primary payer before eligibility due to ESRD	✓	✓for 30-month coordination period
C. When either you or a covered family member are eligible for Medicare solely due to disability and you		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

- **Medicare Advantage**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in Original Medicare or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Private Contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. We will not waive any deductibles, coinsurance or copayments when paying these claims.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs. If you are enrolled in the Uniformed Services Family Health Plan, the Mail Handlers Benefit Plan is primary.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB program, generally your may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If you suffer injuries in an accident or become ill because of another person's act or omission, and you later receive compensation for the injuries or illness from that person or your own or other insurance, you are required to reimburse us out of that compensation for any benefits we paid on your behalf or, if applicable, to you, your heirs, estate, administrators, successors, or assignees. This is known as our right of reimbursement, and is also sometimes referred to as subrogation.

You will have this obligation to reimburse us even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive. Our right of reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without our written consent. In short, we are entitled to be reimbursed for 100% of the benefits we pay on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce this right of reimbursement by asserting a priority lien against any and all compensation you receive by court order or out-of-court settlement, without regard to how it is characterized, for example as "pain and suffering." You must cooperate with our enforcement of our right of reimbursement by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness;
- accepting our lien for the full amount of the benefits we have paid;
- agreeing to assign any proceeds from third party claims or your own insurance to us if we ask you to do so;
- keeping us advised of the claim's status;
- advising us of any settlement or court order;
- and promptly reimbursing us out of any recovery received to the full extent of our right of reimbursement.

You must also sign a Reimbursement Agreement for this purpose when asked to do so. We will not pay benefits until this Agreement is signed. Our right to full reimbursement applies even to benefits we paid before learning of a potential recovery, and before asking you to sign a Reimbursement Agreement; it also applies to any benefits payable on covered expenses incurred but not submitted for payment to us or processed by us before the date of a settlement or court order. Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

If you would like more information about the subrogation process and how it works, please call our Third Party Recovery Services unit at 301-610-0919.

Section 12. Definitions of terms we use in this brochure

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 17.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Plan may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intraoral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services.
See page 15.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

The Plan determines what services are custodial in nature. Custodial care that lasts 90 days or more is sometimes known as Long term care. For instance, the following are considered custodial services:

- Help in walking; getting in and out of bed; bathing; eating (including help with tube feeding or gastrostomy) exercising and dressing
- Homemaking services such as making meals or special diets
- Moving the patient
- Acting as companion or sitter
- Supervising medication when it can be self administered; or
- Services that anyone with minimal instruction can do, such as taking a temperature, recording pulse, respiration or administration and monitoring of feeding systems.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.

Experimental or investigational services

A drug, device, or biological product is Experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is Experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, biological product, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, biological product, or medical treatment or procedure.

If you wish additional information concerning the experimental/investigational determination process, please contact the Plan.

Group health coverage

Health care coverage that a member is eligible for because of employment, by membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Hospice care program

A formal program directed by a doctor to help care for a terminally ill person. The services may be provided through either a centrally-administered, medically-directed, and nurse-coordinated program that provides primarily home care services 24 hours a day, seven days a week by a hospice team that reduces or abates mental and physical distress and meets the special stresses of a terminal illness, dying and bereavement, or through confinement in a hospice care program. The hospice team must include a doctor and a nurse (R.N.) and also may include a social worker, clergyman/counselor, volunteer, clinical psychologist, physical therapist, or occupational therapist.

Medical necessity

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines:

1) are appropriate to diagnose or treat the patient's condition, illness, or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and,
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Morbid obesity

A diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction. Eligible members must be age 18 or over.

Orthopedic appliance

Any fitted external device used to support, align, prevent, or correct deformities, or to restore or improve function.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

PPO allowance: an amount that we negotiate with each provider or provider group who participates in our network. For these PPO allowances, the PPO provider has agreed to accept the negotiated reduction and you are not responsible for the discounted amount. In these instances, the benefit we pay plus any applicable deductible, copayment or coinsurance you are responsible for, equals payment in full.

Managed In-Network allowance: a negotiated amount the mental health/substance abuse provider has agreed to accept as the negotiated reduction and you are not responsible for the discounted amount. In these instances, the benefit we pay plus any applicable deductible, copayment or coinsurance you are responsible for, equals payment in full.

Non-PPO allowance: the amount the Plan will consider for services provided by non-PPO or non-Managed In-Network providers. Non-PPO allowances are determined as follows:

If you receive care in an area that has a fully developed PPO network (one in which you have adequate access to a network provider), but you do not use a PPO network provider the Plan's allowance will be reduced to a rate that the Plan would have paid had you used a PPO provider. This non-PPO allowance is based upon a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area. In industry terms, this is called a "blended" fee schedule. Member out-of-pocket costs resulting from application of the blended rate fee schedule will be limited to $5,000 per occurrence only for inpatient and outpatient hospital services. We encourage you to call us before scheduling any hospital services.

Note: For those members who do not have adequate access to a network provider (in terms of distance from where you receive care to a network provider) or those members receiving emergency care, the Plan's non-PPO allowance will be based on the reasonable and customary charge (as described below), not the "blended" fee schedule.

If you receive care in an area that does not have a fully developed network, and use a non-PPO provider, the non-PPO allowance is the reasonable and customary allowance for your medical or mental health/substance abuse services based on the reasonable and customary charge. This is generally the lesser of either (a) the usual charge made by the provider for the service or supply in the absence of insurance or, (b) the charge that the Plan determines to be in the 80th percentile of the prevailing charges made for the service or supply in the geographic area in which it is furnished. The prevailing charge data is collected by the Plan's underwriter. For certain services, exceptions to the general method of determining reasonable and customary may exist, including the use of NCCI.

If you receive services from a MultiPlan participating provider, the Plan's allowance will be the amount that the hospital/facility or doctor has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at non-PPO benefit levels, subject to the applicable deductibles and copayments.

For more information, see *Differences between our allowance and the bill* in Section 4.

Prosthetic appliance

An artificial substitute for a missing body part such as an arm, eye, or leg. This appliance may be used for a functional or cosmetic reason, or both.

Scooters

A power-operated vehicle (chair or cart) with a base that may extend beyond the edge of the seat, a tiller-type control mechanism which is usually center mounted and an adjustable seat that may or may not swivel.

Sound Natural Tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Us/We

Us and we refer to the Mail Handlers Benefit Plan.

Vested rights

An enrollee does not have a vested right to the benefits in this brochure in 2005 or later years and does not have a right to benefits available prior to 2005 unless those benefits are in this brochure.

You

You refers to the enrollee and each covered family member.

Section 13. FEHB facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren). If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2004 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member no longer eligible for coverage.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy)..

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHBP Web site (http://www.opm.gov/insure/health), and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 14. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS,** lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program** (FLTCIP) covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

Note: If you enroll in the MHBP Consumer Option, you will not be allowed to enroll in the health care flexible spending account plan (HCFSA).

There are two types of FSAs offered by FSAFEDS**:**

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. Note: The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is $4,000 annually. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of $4,000 each ($8,000 total). Both are covered under each other's HCFSA. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you , and your spouse, if married, can work, look for work or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is $5,000. The minimum annual amount is $250. Note: The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online: visit www.FSAFEDS.com and click on Enroll.**
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB– you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the "use-it-or-lose-it" rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 126-128 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include:

- Copayments for doctors' visits and prescriptions
- Coinsurance for diagnostic tests and emergency services
- Deductibles for medical services and prescription drugs
- Amounts in excess of the Plan's Allowance
- Expenses for non-covered services

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes**. Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf. The FSAFEDS web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses ***before*** your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	$50,000	$50,000
And you deposit this amount into a FSA:	$2,000	-$0-
Your taxable income is now:	$48,000	$50,000
Subtract Federal & Social Security taxes:	$13,807	$14,383
If you spend after-tax dollars for expenses:	-$0-	$2,000
Your real spendable income is:	$34,193	$33,617
Your tax savings:	**$576**	**-$0-**

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), your state of residency, and your individual tax situation. In this example, the individual received $2,000 in services for $1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example shown above, only health care expenses exceeding $3,750 (7.5% of $50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at **www.fsafeds.com**, or contact SHPS by email or by phone**.** FSAFEDS Benefit Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. eastern time.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

It's important protection

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?:

- **FEHB plans do not cover the cost of long term care**. Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care**. This coverage gives you control over the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later**. In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply**. The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Standard Option benefits for the Mail Handlers Benefit Plan – 2005

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $300 per person (PPO)/$350 per person (Non-PPO). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximum)	PPO: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children under age 22; $5 copayment per visit for chiropractic care; $5 copayment for allergy injections; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	23 -37
Services provided by a hospital: • Inpatient	PPO: $200 copayment per admission; 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-PPO: $400 copayment per admission; 30% of covered charges and any difference between our allowance and the billed amount (No deductible)	46-48
• Outpatient — surgical facility — laboratory and radiology — hemodialysis, chemotherapy, radiation treatment	PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	30, 49
Emergency benefits: • Accidental injury/Medical emergency	Regular benefits	51-52
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	53-55
Prescription drugs	After $350 per person ($700 per family) calendar year prescription deductible: Network Retail electronic: $10 per Generic drug (No deductible)/$30 per Preferred brand name drug/$45 per Non-Preferred brand name drug Network Retail paper: 50% of the Plan's allowance Non-Network Retail: 50% of the Plan's allowance Mail Order: $10 per Generic drug (No deductible); $40 per Preferred brand name drug; $55 per Non-Preferred brand name drug	56-59
Dental Care	No benefit	N/A
Special features: Flexible Benefits Option; **First Health®** OnCall		60
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $4,500 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $9,000. Some costs do not count toward this protection.	18

Notes

Summary of High Option benefits for the Mail Handlers Benefit Plan – 2005

- **Do not rely on this chart alone**. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $250 per person (PPO)/$300 per person (Non-PPO). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximum)	PPO: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children under age 22; $5 copayment for allergy injections; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	23-37
Services provided by a hospital: • Inpatient	PPO: $100 copayment per admission; 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-PPO: $300 copayment per admission; 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	46-48
• Outpatient — surgical facility — laboratory and radiology — hemodialysis, chemotherapy, radiation treatment	PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	30, 49
Emergency benefits: • Accidental injury/Medical emergency	Regular benefits	51-52
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	53-55
Prescription drugs	After $200 per person ($400 per family) calendar year prescription deductible: Network Retail electronic: $10 per Generic drug (No deductible)/$25 per Preferred brand name drug /$40 per Non-Preferred brand name drug Network Retail paper: 50% of the Plan's allowance Non-Network Retail: 50% of the Plan's allowance Mail Order:$10 per Generic drug (No deductible); $30 per Preferred brand name drug; $45 per Non-Preferred brand name drug	56-59
Dental Care	All charges above amount stated in dental schedule	61-64
Special features: Flexible Benefits Option; **First Health®** OnCall		60
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $4,500 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $9,000. Some costs do not count toward this protection.	18

Notes

Summary of Consumer Option benefits for the Mail Handlers Benefit Plan – 2005

- **Do not rely on this chart alone**. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Under this Plan, most traditional medical care (other than some preventive care) is subject to the Consumer Option deductible. After you meet the deductible, you pay the indicated copayments or coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network provider.

Benefits	You Pay	Page(s)
Preventive care (see specific services)	PPO: Nothing (No deductible) Non-PPO: All charges.	67-68
Traditional Health Coverage		
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits and surgery • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximum)	PPO: $15 copayment per office visit; $15 copayment for allergy injections; $15 copayment for diagnostic X-rays, laboratory services and other professional services. Nothing for Inpatient surgery, maternity and hospital visits. Non-PPO: 40% of the Plan's allowance per office visit; 40% of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	76-85
Services provided by a hospital: • Inpatient	PPO: $75 copayment per day, up to maximum of $750 per admission Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	92-93
• Outpatient — surgical facility — laboratory and radiology — hemodialysis, chemotherapy, radiation treatment	PPO: $25 copayment for outpatient hospital services; $150 copayment for outpatient surgery Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	79, 80, 93
Emergency benefits: • Accidental injury/Medical emergency	PPO: $50 copayment (waived if admitted) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	95
Mental health and substance abuse treatment	In-Network: Regular cost sharing Out-of-network: Benefits are limited	96-97
Prescription drugs	Network Retail electronic: $10 per Generic drug/$25 per Preferred brand name drug /$40 per Non-Preferred brand name drug Mail Order: $20 per Generic drug; $50 per Preferred brand name drug; $80 per Non-Preferred brand name drug Non-Network Retail/Mail Order: Not covered.	98-100
Dental Care	No benefit	N/A
Special features: Flexible benefits option; On-line tools and resources; **First Health**® OnCall		101-102
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	PPO: Nothing after your covered expenses total $5,000 per person ($10,000 per family) per calendar year for PPO providers/facilities. Non-PPO: Nothing after your covered expenses total $7,500 per person ($15,000 per family) per calendar year for Non-PPO providers/facilities. Some costs do not count toward this protection.	19

Notes

2005 Rate Information for the Mail Handlers Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				***Postal Premium***	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	451	$131.08	$151.01	$284.01	$327.19	$154.74	$127.35
High Option Self and Family	452	$298.23	$296.79	$646.17	$643.04	$352.08	$242.94
Standard Option Self Only	454	$131.08	$45.16	$284.01	$97.84	$154.74	$21.50
Standard Option Self and Family	455	$286.93	$95.64	$621.68	$207.22	$339.53	$43.04
Consumer Option Self Only	481	$126.77	$42.25	$274.66	$91.55	$150.01	$19.01
Consumer Option Self and Family	482	$287.27	$95.75	$622.41	$207.47	$339.93	$43.09